IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF WEST VIRGINIA
AT CHARLESTON

THE CITY OF HUNTINGTON,	:	Civil Action
Plaintiff,	:	No. 3:17-cv-01362
v.	:	
AMERISOURCEBERGEN DRUG CORPORATION, et al.,	:	
Defendants.	:	
CABELL COUNTY COMMISSION,	:	Civil Action
Plaintiff,	:	No. 3:17-cv-01665
v.	:	
AMERISOURCEBERGEN DRUG CORPORATION, et al.,	:	
Defendants.	:	

BENCH TRIAL - VOLUME 4
BEFORE THE HONORABLE DAVID A. FABER, SENIOR STATUS JUDGE
UNITED STATES DISTRICT COURT
IN CHARLESTON, WEST VIRGINIA

MAY 6, 2021

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PROCEEDINGS had before The Honorable David A. Faber, Senior Status Judge, United States District Court, Southern District of West Virginia, in Charleston, West Virginia, on May 6, 2021, at 9:00 a.m., as follows:

THE COURT: Mr. Farrell, you have something?

MR. FARRELL: Yes, Your Honor. Two preliminary matters. One is scheduling. So, today we'll continue with the final part of Dr. Gupta and then our intention is we're attempting to have an on-deck batter and a double-deck batter. So, we're hoping to have today Connie Priddy, who will testify. She's on deck. On double deck and prepared today is Scott Lemley from the City. Both of them --

THE COURT: If you were a baseball fan, you'd say below deck.

MR. FARRELL: So, tomorrow -- I'm hoping we get through all three today, maybe spill a little tomorrow. Tomorrow, we have Jan Rader planned for the early morning and we don't -- after Jan Rader, we don't have anybody planned on deck, or double deck, or under deck, below deck, but we do intend to submit, as everybody knows, the two deposition transcripts for your enjoyment to watch. That's Hartle and Prevosnick.

THE COURT: Well, I may have given you an unclear signal, but I intended to say that I was going to review those depositions on my own time so that we wouldn't use

court time to do that. I'll -- I will, no doubt, regret having said that, but that's the plan.

MR. FARRELL: So, I guess to be clear, it's our intention to finish the week with Jan Rader.

THE COURT: Okay.

MR. FARRELL: And so, if we ask questions and at 10:30 in the morning the defense says no questions, we don't have anybody scheduled on Friday after Jan Rader, if that's okay with the Court, and we understand that your video watching time will count against the parties.

THE COURT: Okay. Well, I don't really have any problem with that.

MR. FARRELL: Thank you.

THE COURT: And your opponents will probably be relieved to know that they'll be done by that early on Friday.

MR. FARRELL: Well, it depends on the amount of cross examination, Your Honor, but yes.

The second thing I would like do before we start is I would like to make a proffer for the Court.

THE COURT: Okay.

MR. FARRELL: And it's regarding disclosures of Dr. Gupta. Not making any argument. I'm just going to state a couple of facts.

Dr. Gupta was originally deposed in the AG action,

Morissey v. AmerisourceBergen, on August 10th, 2016 by AmerisourceBergen. That deposition transcript was attached as Exhibit A to his deposition in this case on September 11th, 2020.

Now, importantly, Judge, on October 30th, 2020, the plaintiffs following that deposition re-disclosed in a pleading the opinions that Dr. Gupta we anticipated would present in this trial. This is the source of a lot of personal pain. This is the plaintiffs' supplemental Federal Rule of Civil Procedure 26(a)(2)(C) disclosure where, beginning on Page 7, we line item the things we anticipate Dr. Gupta would say in this courtroom.

The defendants asked you to strike those opinions. You offered them the opportunity to re-depose Dr. Gupta and he was re-deposed on April 15th, 2021. And I wanted to make the record clear that these opinions that he's been expressing have been disclosed in this case and subject to cross examination. Thank you.

MR. HESTER: Your Honor, Timothy Hester. Just to make the record clear from our perspective, we do not believe that his opinions were properly disclosed. I know Mr. Farrell made a proffer and, just to preserve the record, we do not agree with his proffer.

THE COURT: I understand.

MR. FARRELL: Judge, if I may, I brought a copy of

ECF filing 1146-1 that contains the actual disclosures to tender to the Court.

MS. MAINIGI: Your Honor, this -- we were not aware that this was going to be raised this morning. We're prepared to finish out the cross examination of Dr. Gupta. What I would ask is we be allowed to finish that out and then, certainly, if Mr. Farrell wants to continue discussing this, we're happy to do that.

THE COURT: Yes. I think that's the proper way to go, Mr. Farrell. So, we'll finish with Dr. Gupta and we'll then deal with this, if you have anything else.

MR. FARRELL: Thank you.

THE COURT: Dr. Gupta, are you in the courtroom? You may resume the stand. You're still under oath, sir.

MS. MAINIGI: May I proceed, Your Honor? Your Honor, may I proceed?

THE COURT: Yes, please.

MS. MAINIGI: Thank you.

CONTINUED CROSS EXAMINATION

BY MS. MAINIGI:

Q. Good morning, Dr. Gupta.

A. Good morning.

Good morning, Your Honor.

Q. I think yesterday we looked at the 2016 West Virginia

Overdose Fatality Analysis. Do you recall that?

A. Yes.

Q. If you could pull that up, I just double checked this morning. It still seems to be there. Now, I'd like you to turn to Page 58 of your Overdose Fatality Analysis, please, sir. And this is where the Summary of Key Recommendations are, correct?

A. Yes.

Q. Now, do you recall when I asked you yesterday about whether you made recommendations about distributors, you testified that was because -- that you had not because distributors are -- and I think you said something like not within the purview of the Bureau of Public Health. Do you recall that yesterday afternoon?

A. Yes.

Q. You also testified that the Bureau of Public Health does not regulate law enforcement or distributors. Do you recall saying that yesterday?

A. Yes.

Q. I just want to draw your attention to a couple of the recommendations. If we look at the sixth bullet down, sir. The sixth bullet down --

A. Yes.

Q. -- states as follows: "Corrections officials should work with judges to assure naloxone availability, treatment

referral, and peer supports at release of incarceration." Do you see that?

A. Yes.

Q. Now, the Department of Corrections is not within the purview of the Bureau of Public Health, correct?

A. Correct.

Q. And the Bureau of Public Health does not regulate the Department of Corrections, right?

A. Correct.

Q. And judges are not within the purview of the Bureau of Public Health either, correct?

A. Correct.

Q. And the Bureau of Public Health does not regulate judges, right?

A. That's correct. And I am happy to explain that recommendation, if you would allow me to.

Q. I don't think it's necessary right now, but thank you. Let's look at number -- the third recommendation down. And that third recommendation is, "Enhance CSMP Advisory Committee legislation to identify abnormal or unusual prescribing and dispensing patterns and to permit sharing this data with appropriate professional licensing boards and other agencies." Do you see that, sir?

A. Yes.

Q. Now, the Board of Pharmacy runs the CSMP, correct?

A. Correct.

Q. Not the Bureau of Public Health, correct?

A. That's not correct.

Q. The Board of Pharmacy is within the purview of the Bureau for Public Health?

A. That's not correct.

Q. Okay. So, the Board of Pharmacy is not within the purview of the Bureau of Public Health, correct?

A. That's correct.

Q. And the Bureau of Public Health does not regulate the Board of Pharmacy?

A. That's correct.

Q. And the Bureau of Public Health does not regulate the state legislature, I assume?

A. That would be correct.

Q. Now, you have made several recommendations to the legislature about what it should do or should consider doing; is that not true?

A. That is true. And, once again, I'm really happy to explain the intricate relationships of agencies in the State of West Virginia, including the Bureau of Public Health relationship with the Board of Pharmacy --

Q. Thank you, sir.

A. -- and with Corrections.

Q. Thank you. I think one of the -- one of the

contributions that I assume you are the most proud of from your time as State Commissioner is your involvement with the Opioid Reduction Act, right?

A. Yes.

Q. Now, coming back to the Board of Pharmacy, the Board of Pharmacy regulates distributors, right?

A. I have -- I have -- again, once again, I do not -- Board of -- Bureau for Public Health does not regulate as you correctly outlined. Board of Pharmacy, you would have to ask Board of Pharmacy who they regulate and who they do not.

Q. Fair enough. Now, coming back to your involvement, from time to time, as you said, you get involved in recommendations to the legislature, correct?

A. Correct.

Q. And that's from your purview originally -- well, from recent -- most recently from your purview as the State Commissioner of Health, correct?

A. That's one of the ways.

Q. And another way is that when you were the Health Officer, the lead Health Officer at Kanawha-Charleston, you also made some recommendations or were involved with legislation, right?

A. So, I sit -- I sat on about 30-plus boards. Once again, I'm happy to explain my involvement but, yes, that

would be correct, as well, but one of the several, several other ways.

Q. Okay. You can set that report aside for now, Mr. Gupta.

So, are you familiar with Senate Bill 437, Dr. Gupta?

A. Ms. Mainigi, you would have to state the year and I would have to look at it because the Senate Bill 437 potentially occurs in every legislative session in state legislature.

Q. That's a great point. I apologize for that. This is Senate Bill from -- Senate Bill 437 from 2012. And why don't I get a copy to you of that so you can take a look at it.

UNIDENTIFIED SPEAKER: May I approach?

THE COURT: Yes.

BY MS. MAINIGI:

Q. Now, Dr. Gupta, while you are taking a look at that, I will just note for you for the record that Senate Bill 437, I think, is something that I saw on your CV and you noted it as substance abuse legislation and you noted on your CV your role as the following: "Supported the Governor's Substance Use Disorder initiative as social determinate of health initiative, passed the legislature, and approved by Governor Tomblin on 3/29/2012." And I offer that to you just to jog your memory on this.

Let me know when you're ready, Dr. Gupta.

A. I have not had the opportunity to review this bill and I have made my best attempt to take a very superficial look at this, but I just want to say for the record again that this is prior to my position as being the Bureau for Public Health Commissioner.

Q. Understood, Dr. Gupta. I raise it as -- and I'm happy to put your CV in front of you. I don't think we need to, though, unless you really want it, but your CV refers to Senate Bill 437, as I mentioned, as substance abuse legislation that in the role that you had in 2012 was -- which was as Kanawha-Charleston Health Officer, that you supported the Governor's Substance Use Disorder initiative. Do you agree with that?

A. I would agree with that. And I'm happy to look at which portions of this. I did not draft the bill.

Q. Understood. Understood. I understand that.

A. So, there are pieces that -- I think it would be unfair to characterize supporting the entire bill and I am happy to look at the pieces that were relevant to my position at the time that I would have supported it.

Q. Okay. Fair enough. Well, let me ask you a couple of questions and you're obviously free to continue looking at the bill. Dr. Gupta, you're aware that Senate Bill 437 required continuing medical education for all prescribers of

controlled substances, correct?

A. Yes, correct.

Q. And the purpose of the continuing education was to educate prescribers about when they should and should not prescribe opioids, correct?

A. Again, having said that, I have not reviewed the entire bill. The purpose of the legislation was to ensure that prescribers had the appropriate training and understanding what it takes in order to prescribe opioid prescriptions.

Q. Thank you. Another thing that Senate Bill 437 did in 2012 was it enhanced the use of the Controlled Substances Monitoring Program, correct?

A. If you say so.

Q. Do you recall that it did?

A. In my position as the local health officer of Kanawha-Charleston Health Department, I had no role with the Controlled Substance Monitoring Program.

Q. You came to have a role with it as the State Health Officer or no?

A. Ms. Mainigi, I was trying to explain that, but you denied my request to explain that just a minute ago.

Q. Because the -- excuse me -- because the Board of Pharmacy oversees the CSMP, correct?

A. I will be very happy to explain my role as the Commissioner for Public Health and involvement of the

Controlled Substance Monitoring Program and the Board of Pharmacy, if I'm allowed to, in this court.

Q. Well, let's just step back for a moment and let's define it. The CSMP, Dr. Gupta, the Controlled Substances Monitoring Program, is essentially a database of all the controlled substances prescriptions filled in the state, right?

A. In my role as Commissioner for Bureau for Public Health, my understanding of the Controlled Substance Monitoring Program was that it's a database of between Schedule II and Schedule IV. So, it does not have Schedule I substances. So, I just wanted to correct you on that.

Q. And the CSMP, as it's known, is not open to the public, correct?

A. Controlled Substance Monitoring Program is not open to the public.

Q. And distributors don't have access to the CSMP, correct?

A. I do not have that information.

Q. Okay. So. Coming back to SB-437, do you recall that one of the things that SB-437 accomplished was to enhance the use of the CSMP?

A. I can explain to you, Ms. Mainigi, what my role was in this legislation as we're speaking here as a local health officer at the time. I am not able to testify to exact --

every piece of this legislation because I did not have that role, as I explained.

Q. When you became the State Health Officer, obviously, with the ownership for the whole state, you obviously had an interest in the CSMP, right?

A. Yes, and I would love to explain that to you, if you allow me to.

Q. Okay. Well, we don't need to do that right now. If you could turn to -- if you look at the bottom numbers on the lower right, DEF-WV-00027696, Dr. Gupta.

A. I'm there.

Q. And you'll see Article 9 relates to the Controlled Substances Monitoring Program. And why don't you just take a moment and read that to yourself, sir.

MS. KEARSE: Can you give me that page number again?

MS. MAINIGI: Sure. It is bottom right, 00027696.

THE WITNESS: I've been able to read Article 9, Section 60(a)-9-3, subsections (a), (b), (c), numbers 1 and 2.

BY MS. MAINIGI:

Q. Terrific. And do you agree that one of the purposes of SB-437 was to enhance the use of the CSMP?

A. I would agree not being practically engaged in SB-437 on this matter.

Q. And the continuing -- the CSMP, the enhancement of the CSMP, that related to doctors, correct?

A. Not only doctors.

Q. Prescribers?

A. Not only prescribers.

Q. It certainly affected prescribers, correct?

A. Not only prescribers.

Q. And the medical education certainly affected prescribers, correct?

A. It did affect prescribers of Schedule II to Schedule IV substances.

Q. And were you aware that one of the other things that SB-437 accomplished was that it established state regulation of pain clinics and MAT programs?

A. I was generally aware as a member of the public. I did not have a specific role in this particular legislation with relation to that.

Q. And the regulation that pain clinics and MAT programs also related to doctors, correct?

A. In my role as local health officer, I could not tell you that at this time.

Q. And are you aware that Senate Bill 437 did not impose new regulatory requirements on distributors?

A. I am not aware.

Q. Are you aware it didn't impose any new licensing

requirements on distributors?
A. I am not aware.
Q. Are you aware that it didn't impose any new reporting requirements to the Board of Pharmacy?
A. I'm not sure. If you can repeat the question in regards to Board of Pharmacy.
Q. Are you aware that it did not impose new reporting requirements for distributors to the Board of Pharmacy?
A. I'm not aware.
Q. Are you aware that Senate Bill 437 did not limit the volume of opioids that a pharmacy could purchase?
A. I am not aware of that.
Q. Now, you can set that aside, sir.

Let me come back to the Controlled Substances Monitoring Program for a moment. Before 2016, is it fair to say prescribers were not required to utilize the CSMP?
A. I could not give you an opinion on that.
Q. Okay. As State Health Officer you don't have knowledge -- you didn't have knowledge in that period of time regarding the CSMP?
A. I came into the office in 2015 and I can provide you information and knowledge as to my role with the CSMP, as well as Board of Pharmacy, and I can also provide you my role as a practitioner. I can also provide you information on my role as a Secretary of the Board of Medicine and the

relationship to the Board of Pharmacy and CSMP. So, I'm happy to provide the Court all of that information if -- if it desires so.

Q. Okay. Thank you, Dr. Gupta. Let me just ask you again, in your role as State Health Officer, were you familiar with the CSMP?

A. Yes.

Q. And are you familiar with the fact that prior to 2016, prescribers were not required to register with the CSMP?

A. I do not exactly remember that, recall that. I would -- I would say that the guidelines prior were more voluntary. That's the way I would characterize that.

Q. And while you were State Health Officer, obviously with a great concern about opioids and other controlled substances, do you recall that in 2016 Senate Bill 454 which related to the CSMP was signed into law by Governor Tomblin?

A. I do recall that.

Q. And you supported this legislation, correct?

A. That would be accurate.

Q. And that bill made it a requirement that all physicians who prescribed controlled substances had to register with the West Virginia CSMP, correct?

A. Once again, I would love to see the bill before I can assert to that statement.

Q. Is that what you generally recall about the bill,

however?
A. I would -- I recall legislation requiring registration of prescribers of Schedule II to IV with the State's Controlled Substance Monitoring Program around that time period.
Q. And do you recall that the number of prescriber registrants nearly doubled as a result of this legislation?
A. I do not have factual knowledge to that fact at this time.
Q. Do you recall that Senate Bill 454 also required prescribers to check a patient's history before prescribing an opioid?
A. Around that time, the legislation would have required, along with registration, to also ensure that physicians were looking to see if there are more than one pharmacy or more than one prescriber, actually, for Controlled Substance Monitoring Program.
Q. So, prior to Senate Bill 454, physicians were not required to check the patient's prescription history before writing an opioid prescription, correct?
A. I believe the appropriate statement of that would be that physicians were able to voluntarily do that, but they were not required by state law.
Q. And one of the things, a requirement to check the patient's prescription history accomplished, was prescribers

could now see, since they were required to do it, if a patient had filled prescriptions at multiple pharmacies, right?

MR. FARRELL: Objection, Your Honor.

THE COURT: Basis?

MR. FARRELL: She's asking a witness about the purpose of a law.

MS. MAINIGI: Your Honor, I'm not asking him about the purpose of the law. I'm asking --

THE COURT: You're asking what the law said, right?

MS. MAINIGI: Correct, Your Honor.

THE COURT: Overruled. Go ahead. You can answer it.

THE WITNESS: Thank you, Your Honor. I'm not able to answer accurately and factually to your question.

BY MS. MAINIGI:

Q. Okay. Let me put Senate Bill 454 in front of you, Dr. Gupta. I'm sorry I failed to do that. Senate Bill 454, for the record, is DEF-WV-03015 and, Dr. Gupta, you're welcome to read any page you want, but I'll draw your attention to one of the last pages, Page 25 in the bottom right. And I think the section is entitled, sir -- it's Section 60A-9-5a and it's entitled "Practitioner Requirements to Access Database and Conduct Annual Search of the Database; Required

Rulemaking."

Let me know when you're ready, Dr. Gupta.

A. I'm here on the page.

Q. And let me just -- I'm not sure I have that much more, Dr. Gupta, on this, but I just wanted to confirm that the record is clear Senate Bill 454 required prescribers to check a patient's history before prescribing an opioid, correct?

A. I am trying to look for that particular language before I can answer your question. It says, "Upon initially prescribing or dispensing any pain-relieving controlled substance for a patient and at least annually thereafter should be -- should the practitioner or dispenser continue to treat the patient with controlled substances, all persons with prescriptive or dispensing authority and in possession of a valid Drug Enforcement Administration registration identification number and, who are licensed by the Board of Medicine as set forth in Article III, Chapter 30 of this code, the Board of Registered Professional Nurses as set forth in Article 7, Chapter 30 of this code." It goes on to say, basically, according to that.

Q. Thank you, Dr. Gupta. Now, you're not aware that this bill provided distributors with access to the CSMP, correct?

A. Once again, I have not thoroughly studied the bill. I cannot provide that answer to you.

Q. You can set that aside, sir.

Now, in 2016, Dr. Gupta, while you were State Health Commissioner, you are aware that the CDC issued guidelines for prescribing opioids for chronic pain, correct?

A. Yes.

Q. Okay. And after the CDC guidelines came out, you are aware that West Virginia convened an expert panel to issue new pain management guidelines, correct?

A. Correct.

Q. And you were a member -- and those were called the SEMP guidelines; is that right?

A. I would recall that at this point, yes.

Q. The -- and SEMP stands for Safe and Effective Management of Pain Guidelines; does that sound right?

A. That would sound accurate to my recollection, but I don't have the guidelines in front of me right now, so I am not sure.

Q. Okay. Let me get those for you, please. And, Dr. Gupta, I probably won't spend that much time on these, but do you agree that the SEMP -- that the -- excuse me -- the expert panel that issued the new pain management guidelines, that those guidelines were called the Safe and Effective Management of Pain Guidelines?

A. I'm sorry. What's the question?

Q. Do you agree that the guidelines were called the Safe

and Effective Management of Pain Guidelines?

A. Yes.

Q. And those were issued in 2016, correct?

A. That's the date on this document.

Q. And if you turn to Page 4 of the document, sir, that document, that page of the document, lists the members of the panel, correct?

A. That's correct.

Q. And you were on that panel, as you said, correct?

A. That's correct.

Q. And the panel was chaired by Dr. Timothy Deer, correct?

A. Correct.

Q. And the panel issued guidance to prescribers and dispensers as an expansion to the CDC Chronic Pain Opioid Guidelines, correct?

A. I wouldn't describe it like that.

Q. If you could take a look at Page 4, sir, do you see the first sentence in the first full paragraph?

A. I do.

Q. And that sentence reads, "This overall pain management guidance is intended for both prescribers and dispensers as an expansion to the 2016 CDC Chronic Pain Opioid Guidelines." Is that what it says?

A. It says that.

Q. Now, these guidelines ultimately came to be endorsed by

multiple health professional organizations in West Virginia, correct?

A. There are several. Multiple would be correct, but I can -- I am happy to explain the context of it, if you would like me to.

Q. Do you recall that the West Virginia State Medical Association endorsed these guidelines?

A. I'm going to go through and see which ones. I don't see it listed in my quick browsing.

Q. Okay. Let me come back to the sentence for a moment. A prescriber is someone who prescribes opioids, right?

A. Not necessarily. A prescriber can prescribe many more pharmaceutical compounds, non-pharmaceutical compounds, in addition to opioids.

Q. Fair enough. And a dispenser is someone like a pharmacist who dispenses drugs?

A. Dispenser in medicine could be a lot of people beyond pharmacy.

Q. Okay. Now, in 2018, I think we talked about this yesterday. You also -- you can set that aside, sir.

You also helped draft Senate Bill 273; is that correct, which it came to be known as the Opioid Reduction Act?

A. That's correct. I'm much more familiar with that one.

Q. And you viewed the Opioid Reduction Act as a reasonable effort to address the contemporary crisis that we were

facing, correct?

A. That would be accurate.

Q. And the Opioid Reduction Act imposed new limits on opioid prescriptions; is that right?

A. As a state level effort, yes.

Q. And, for example, it limited prescriptions for minors to three days, correct?

A. I would love to see that, once again, in front of me because I do not recall every section of the Senate Bill 273 sitting right here.

Q. But you recall as a general matter that there were days supply limitations imposed on opioids as part of the Opioid Reduction Act?

A. I recall as a general matter the attempt of the Opioid Reduction Act was to follow good science, good evidence, and create guidelines based on that in legislation.

Q. And what that involved in part was setting days supply of limitations on the prescription of opioids, correct?

A. What that involved in part was following CDC guidelines and transitioning those evidence-based guidelines into legislation that included limitation of initial prescriptions to -- for prescribers.

Q. So, for example, do you recall that it allowed for a seven-day prescription if the medical purpose said that it supported it in the record?

A. So, once again, I would love to see that in front of me because we had debated back and forth three days, four days with different committees and it was a matter of negotiation. So, but I do recall that for initial prescribing, I believe it was about four days and, for some other reasons, it was seven days. So, there were variations in that within the legislation.

Q. And there was limitations imposed on dentists, also, correct?

A. That would be accurate.

Q. Because some dentists -- dentists were allowed to prescribe opioids after certain dental procedures, correct?

A. You've asked me why it was a limitation on dentists. My answer is there were limitations on prescribers for controlled substances beyond physicians because there was such a volume that was being provided and prescribed by and in communities that was -- that included prescriptions from dentists and other providers, as well.

Q. And do you recall that there was a three-day limitation for dentists?

A. I don't recall the exact limitation of every profession in the bill at this time while I'm sitting here.

Q. Do you recall it was around three days?

A. Three to seven days, three to five days is usually the evidence-based best practice for initial prescribing. So,

that would be the area, but if I saw the legislation, I would be able to tell you more definitively.

Q. And prior to this Opioid Reduction Act, a dentist could have prescribed a 30-day supply of opioids, correct?

A. Certainly.

Q. And, to your knowledge, the Opioid Reduction Act did not contain any new requirements for distributors, correct?

A. I do not have that stationed in front of me to say that at this point.

Q. And, to your knowledge, the Opioid Reduction Act did not impose limits on the distributions of opioids to pharmacies, correct?

A. Could you please repeat that again?

Q. Sure. To your knowledge, the Opioid Reduction Act did not impose limitations on the distributions of opioids to pharmacies?

A. I -- I cannot recall for or against that.

Q. Now, one of the things you said yesterday, Dr. Gupta, when you were being asked questions by Ms. Kearse was where West Virginia ranks compared to the country is -- was important for you to know as the State Health Commissioner, correct?

A. Correct.

Q. Let me put another exhibit in front of you.

MS. MAINIGI: Could I have DEF-WV-00747, State of

Health presentation?

BY MS. MAINIGI:

Q. Now, Dr. Gupta, this is a PowerPoint presentation that you put together in August, 2018 entitled "Public Health in West Virginia: Brief History and Current State of Health," correct?

A. That's what it states, correct.

Q. And this particular report happens to have your name on the front, correct?

A. This one does. This presentation does, as well.

Q. And was this a presentation that you made to others in the State of West Virginia?

A. This was a presentation and it states on the report I made on August 6th, 2018 to the sanitarian training.

Q. If you could turn to Page 38 of your report, Dr. Gupta.

A. I'm here.

Q. Now, at Slide 38, there's a chart comparing annual prescription per capita in 2016 across all the states; is that right?

A. That's correct.

Q. And where does West Virginia rank?

A. It's highlighted as ranking number one.

Q. Okay. And what does the number 20.8 mean?

A. That means 20.8 prescriptions per 100 -- per -- actually, per person, per capita.

Q. And that means West Virginia ranked number one in total prescriptions at that point in time, correct?

A. That's correct.

Q. And that's not just opioid prescriptions. This is all prescriptions, correct?

A. That's correct.

THE COURT: Does that mean 20 prescriptions for every person in the state at that time?

THE WITNESS: Yes, Your Honor.

THE COURT: Is that what that means?

THE WITNESS: Yes, Your Honor.

BY MS. MAINIGI:

Q. Now, if you could take a look at Page 68 -- oh, excuse me. Not 68. Let me back up.

I believe you have testified before, Dr. Gupta, that West Virginia has a higher than average incidence of people in circumstances that lead to pain, like manual labor jobs, correct?

MR. FARRELL: Excuse me, Your Honor. Can we have a date and page reference to his prior testimony?

THE COURT: Yes. Yes

MS. MAINIGI: Sure. Let's go ahead and put Dr. Gupta's 2016 deposition up at Page 68, Lines 6 through 15.

MR. FARRELL: Objection, Your Honor, unless we intend to do cross examination by showing cross examination.

MS. MAINIGI: Well, you asked for a citation, so I thought I'd put it up. Do you not want me to put it up?

THE COURT: Do you want it down, Mr. Farrell?

MR. FARRELL: No. I'm just curious as to whether or not we're going to be allowed to show cross examination to witnesses before we actually cross examine them. I'm okay with that.

MS. MAINIGI: I thought you asked for a citation, so I thought I'd put it up because you might not have it handy.

THE COURT: Well, I'm going to let -- I'm going to allow this. We need to get through this. Go ahead, please.

MS. MAINIGI: Yes, Your Honor.

Let's go ahead and put it up, Matt, please.

BY MS. MAINIGI:

Q. And in your 2016 deposition, you were asked, Doctor Gupta, How would you characterize the rate of legitimate pain in West Virginia", and you responded at that point in time, "I would characterize it by the following. There's reason to believe, certainly, that because of the mining and number of other labor activities that West Virginians have - traditionally have had a lot of laborious work in the industry and, as a result, that one can argue that historically that could be higher levels of pain related to the work in those industries." Do you recall testifying in

that manner?

A. Ms. Mainigi, I do not have in front of me this deposition from five years ago and you're going to have to allow me to explain those statements if you expect me to answer questions related to these statements.

Q. Okay. Let me turn first, before we come back to that, to Slide 27 of your presentation. Now, this slide lists West Virginia morbidity indicators, correct?

A. This slide lists West Virginia morbidity indicators as per the Behavior Risk Factor Surveillance System of 2016 as reported by Health Statistics Center at DHHR.

Q. West Virginia ranks number one in arthritis; is that correct?

A. That's correct.

Q. And can you explain to me what that means?

A. Thank you for the opportunity. Arthritis is a condition one can develop from a lot of reasons and we -- the ranking of arthritis in the nation is important where West Virginia ranks, but the trend data is equally important. For example, we have seen a mere two percentage point of increase in arthritis over more than a decade in West Virginia.

So, while it ranks number one, it has always been close to number one. So, there was not a tsunami of increase in the cases of arthritis in the period of time we're talking

about.

Q. Dr. Gupta, let's take a look at the number there. 38.9 percent is the West Virginia prevalence of arthritis in 2016?

A. Yes.

Q. And the country was at 25.3 percent --

A. Yes.

Q. -- on average? Okay. Poor health limitations, where did West Virginia rank?

A. Once again, in 2016, it ranked --

Q. Dr. Gupta --

A. I'm answering your question.

Q. Okay. Where did West Virginia rank in 2016?

A. It ranked number one at 23.6 percent for that particular year.

Q. Okay. And for cardiovascular disease, where did West Virginia rank in the country?

A. For 2016, it ranked at 14.6 percent, number one, which has been consistent over the years, without a significant change over the years.

Q. And, Dr. Gupta, I'd appreciate it if you would just answer the question. Where did West Virginia rank for COPD in 2016 according to your chart?

A. One.

Q. And where did West Virginia rank in hypertension

according to your chart in 2016?

A. One.

Q. And where did West Virginia rank for diabetes in 2016 according to your chart?

A. Two.

Q. And where did West Virginia rank for depression in 2016 according to your chart?

A. Two.

Q. And where did West Virginia rank in 2016 for cancer according to your chart?

A. Three.

Q. And all of the conditions I just described, Dr. Gupta, all of those conditions could result in pain for the individuals who suffer from them, correct?

A. Not necessarily. And I'm happy to explain that again, if you would like me to.

Q. Thank you. Now, let's turn to Page 24 of your presentation. This page is entitled "West Virginia Demographics", correct?

A. Correct.

Q. And the median age for West Virginians in 2016 was the fourth highest in the nation based on census data, correct?

A. That's what it says.

Q. This page also notes that West Virginia had a higher than average disabled population, correct?

A. It states there was -- 18 percent report being disabled.

Q. And turning to Page --

MS. MAINIGI: Actually, why don't we go ahead and take that down.

BY MS. MAINIGI:

Q. Thank you, Dr. Gupta.

Dr. Gupta, you are an expert for the plaintiffs in the MLP opioid cases, correct?

A. Correct.

Q. And you are an expert in abatement?

A. Correct.

Q. And you get paid $500.00 an hour; is that correct?

A. As I mentioned in my deposition, I don't exactly recall the exact hourly rate.

Q. Is that approximately how much you get paid an hour?

A. Could be plus, minus.

Q. And you were originally retained by Mr. Colantonio in this case?

A. I do not -- that would not be accurate.

Q. Who were you originally retained by?

A. That was Natalie Shkolnik.

Q. And are you retained by Mr. Colantonio in this case?

A. As my personal attorney capacity. He's functioning as my personal attorney on this.

MS. KEARSE: Can I get clarification of what, Your Honor, just -- what case? When you say "this case"?

MS. MAINIGI: I apologize. That was unclear. I will clarify.

BY MS. MAINIGI:

Q. In -- Mr. Colantonio is serving as your personal attorney in this matter that you're testifying --

A. Yes.

Q. -- here for today?

A. Yes.

Q. Okay. Is Mr. Colantonio also your attorney in the MLP cases?

A. Natalie Shkolnik is the attorney that I'm dealing with in the MLP case.

Q. Now, Mr. Colantonio is here today in the courtroom, right?

A. Correct.

Q. Okay. And Mr. Colantonio, did he take part of your deposition when you were deposed by us in this matter?

A. There was two depositions. Could you please clarify which one?

Q. Let me clarify for you.

A. You're confusing me.

Q. That's a fair point. That's a fair point. So, in 2020, you were deposed in this matter, correct?

A. There was one deposition in September of 2020, correct.
Q. And at that deposition in September of 2020, you were deposed by the defendants in this case, correct?
A. Correct.
Q. And you were also deposed by Mr. Colantonio in that case, correct?
A. I was asked questions by Mr. Colantonio at that deposition, yes.
Q. Okay. And are you aware that Mr. Colantonio is also counsel to Cabell County and City of Huntington in this matter?

MR. FARRELL: Objection. Lack of foundation.

THE COURT: Overruled.

BY MS. MAINIGI:

A. I'm not aware of that, actually.
Q. Now, do you recall what year you were first retained as an expert? Was it 2019?
A. It would be close to that.
Q. Now, do you recall speaking at a plaintiffs counsel conference in 2018 in Fort Lauderdale, Florida?
A. If you could tell me more specifics about it, I used to travel a lot in my role as the Commissioner for Bureau for Public Health, so I'm happy to recall that, the details.
Q. Sure. Let's go ahead and put that up on the screen and see if it jogs your memory. We can back up to the Opioid

Crisis Summit, July 21st-22nd, 2018. Do you recall speaking at this conference called the Opioid Crisis Summit, July 21st-22nd in 2018?

A. I would have traveled there in my capacity as the Commissioner of Bureau for Public Health. Again, my schedule travels.

Q. Are you aware that the purpose of this conference was explaining to plaintiffs firms how to make money in mass tort cases?

A. No.

Q. But your testimony is you traveled there as the Commissioner of Public Health?

A. My testimony is that I was asked to speak specifically about the opioid crisis in West Virginia to -- to this meeting and in that role I was traveling to many conferences, including the American Automobile Association and, you know, a number of other organizations that were not pure public health. That was the role I was -- and this was in that role.

Q. Now, if we look at the second page of this --

MS. MAINIGI: Matt, if we we could turn to the next page.

BY MS. MAINIGI:

Q. Were you aware that people paid $1,495.00 to attend this conference?

A. No, I was not aware.

Q. Were you aware that the purpose of the conference was to teach plaintiffs lawyers how to file more opioid cases?

A. No, Ms. Mainigi. My role as Commissioner for Bureau for Public Health is to go speak and talk about the public health impact of the opioid crisis in West Virginia. When I get invited, I will go speak and explain what is happening in order to advance the knowledge and understanding of all types of people from the country and I do not go back to figure out who is paying what and who is there. I just -- that's not what I did in my role.

MS. MAINIGI: If we could turn to the agenda of events, please, Matt. Next page, please. If we could go to the next page, please. Okay. Maybe you can blow that up a little bit, Matt.

BY MS. MAINIGI:

Q. And so, do you see your name here as one of the speakers, Dr. Gupta?

A. This is the first time I've seen this, so I'm happy, if you have paperwork, to look at that because I have never seen this particular agenda before, but I do see my name there.

Q. Okay. And do you see that at the bottom of this page it says as follows: "Attorneys in attendance will be given specific information regarding the signing of both entity

and individual cases, regarding case criteria, damage models and estimated time frames for settlement"? Do you see that?

A. I see it, but this is my first time seeing it.

Q. So, is it your testimony you weren't aware that the purpose of the conference was to educate plaintiffs attorneys to bring opioid cases?

A. I was absolutely not aware of that.

MS. MAINIGI: I have no further questions. Thank you, Dr. Gupta.

MR. FARRELL: Judge, before Ms. Mainigi retires, can we get a copy of the demonstrative that was just --

MS. MAINIGI: I'm happy to provide a copy. Actually, for housekeeping purposes, Your Honor, it may be simpler if I -- if Mr. Hester is going next, if I provide a list -- we provide a list together at the end of the exhibits we'd like to move into evidence. Would that --

THE COURT: Is that all right with you, Mr. Farrell?

MS. MAINIGI: Just to save time.

MR. FARRELL: I'd like do it now. I'd like to make a record, as well.

MS. MAINIGI: Sure. Sure. Absolutely.

Your Honor, I'd like to move Senate Bill 437 into the record. That is DEF-WV-03105.

THE COURT: Any objection?

MS. KEARSE: No objection, Your Honor.

THE COURT: It's admitted.

DEFENSE EXHIBIT DEF-WV-03105 ADMITTED

MS. MAINIGI: I'd like to move Senate Bill 454 into the record. That is DEF-WV-03015.

THE COURT: Any objection?

MS. KEARSE: No objection, Your Honor.

THE COURT: Admitted.

DEFENSE EXHIBIT DEF-WV-03015 ADMITTED

MS. MAINIGI: I'd like to move the 2016 SEMP Guidelines into the record. That is DEF-WV-03036.

MS. KEARSE: No objection, Your Honor.

THE COURT: Admitted.

DEFENSE EXHIBIT DEF-WV-03036

MS. MAINIGI: I'd like to move into the record DEF-WV-00747, which is the Public Health in West Virginia Brief History and Current State of Health.

MS. KEARSE: No objection.

THE COURT: Admitted.

DEFENSE EXHIBIT DEF-WV-00747 ADMITTED

MS. MAINIGI: And I believe that's it, Your Honor. Thank you.

THE COURT: Thank you.

MR. FARRELL: I'm sorry. Did we get the CLE program admitted?

MS. MAINIGI: He didn't recognize it, so I didn't move it into the record, but I'm happy to move it into the the record, if you would like.

THE COURT: Do you want it in, Mr. Farrell?

MR. FARRELL: I just want a copy, is all I would like.

MS. MAINIGI: We'll get him a copy right here and, Your Honor, could I go ahead and just ask that that also be moved into the record, that agenda?

THE COURT: Is there any objection?

MR. FARRELL: None.

THE COURT: It's admitted.

MS. KEARSE: Can I object?

COURTROOM DEPUTY CLERK: Judge, we need a number, an exhibit number.

THE COURT: We need exhibit numbers.

MS. MAINIGI: Yes, Your Honor.

THE COURT: Can you give those to the clerk so she can keep her record straight?

MS. MAINIGI: Oh, 861. That sounds more like it. So, Opioid Crisis Summit, July 21st-22nd, 2018 is Exhibit 861.

DEFENSE EXHIBIT 861 ADMITTED

MR. HESTER: Your Honor, should I go ahead now or do you want to take a break?

THE COURT: Well, it's only 10:00. Let's press on, Mr. Hester, if you're ready.

MR. HESTER: We'll press on. All right. Just take us a minute, Your Honor, to get set up.

CROSS EXAMINATION

BY MR. HESTER:

Q. Good morning, Dr. Gupta.

A. Good morning.

Q. My name is Timothy Hester. I represent McKesson.

Dr. Gupta, I want to begin just by asking a couple of threshold questions where I think we can have pretty ready agreement. Do you agree with me that licensed doctors and other healthcare providers in West Virginia are responsible for making prescribing decisions?

A. Yes.

Q. And so, the number of prescriptions written in Huntington and Cabell County for prescription opioids would be based on the decisions made by doctors and other prescribers, correct?

A. The number of prescriptions that would -- would be going to pharmacies would be coming out of offices of healthcare providers.

Q. So, based on the judgment of healthcare providers, doctors, and other prescribers, correct?

A. I would say they were the ones writing the

prescriptions.

Q. And so, they were the ones making the decision to write the prescriptions, correct?

A. That would be accurate.

Q. And so, you also agree and understand that an opioid pill cannot leave a pharmacy lawfully unless a prescriber decides to write a prescription and the pharmacist decides to dispense it, correct?

A. That would be accurate.

Q. So, the number of prescriptions written in Huntington and Cabell determines the amount of legal opioid pills that would have been dispensed in the community, correct?

A. That would not be correct.

Q. The pills can't leave the pharmacy shelf unless prescriptions are written for them, correct?

A. That's correct.

Q. And so, the total volume of prescriptions would be total volume of pills that would be -- would reflect the total volume of pills that could leave the pharmacy, correct?

A. That's correct.

Q. Let me ask you to return a bit to the discussion you just had with Ms. Mainigi relating to pain needs in West Virginia. Do you agree that West Virginia historically has had a very significant proportion of its population engaged

in labor-intensive jobs such as mining?

A. That would be correct.

Q. And are those labor intensive jobs a factor that have tended to drive higher levels of pain needs in this state?

A. I would characterize it a different way, so I could not exactly agree with that characterization.

Q. You understand that heavy manual labor jobs tend to create over time higher needs for pain in a given population?

A. I do not understand the term "higher needs for pain".

Q. Let me ask to -- let me put up on the screen the 2016 deposition pages, Page 68 Line 6 to 15, please. And, Dr. Gupta --

MS. KEARSE: Your Honor, I'm going to -- is this impeachment? I don't know that he's actually set a foundation.

MR. HESTER: I think the witness said he didn't -- wouldn't characterize the question the way I asked him and this is meant to respond to that.

MS. KEARSE: And I think --

THE COURT: He hasn't identified the document and related it to this witness, is that what you're saying?

MS. KEARSE: Yeah. I think he was about to explain his answer with that and so, I don't think this is proper impeachment.

THE COURT: Overruled. I'm going to let him go ahead. This is cross examination. We need to give Mr. Hester some latitude here.

So, go ahead, sir.

BY MR. HESTER:

Q. Dr. Gupta, you were deposed in 2016 in this litigation. Do you remember this?

A. I remember being deposed. I do not remember signing an errata statement to review this deposition and correct it to the accuracy of my deposition. So, I cannot speak to this because I have not signed an errata statement and I have not reviewed the deposition.

MR. HESTER: Well, Your Honor, if the witness -- if the witness didn't sign an errata statement, it's been waived by now.

THE COURT: Well, is this -- is this the testimony you gave in this deposition?

THE WITNESS: Your Honor, I was -- I did not -- I was deposed. I never signed an errata statement, so I have never had an opportunity to go back and review my deposition of 2016.

THE COURT: Well, I understand that, but if you testified under oath and this is your testimony, then I think this is fair game.

Go ahead, Mr. Hester.

BY MR. HESTER:

Q. Dr. Gupta, you were under oath when you gave this testimony, correct?

A. Yes.

Q. And the testimony, the question was, "Has, or how would you characterize the rate of -- let me use the words legitimate pain in West Virginia." Do you see that question?

A. Yes.

Q. And your answer was, "I would characterize it by the following. There's reason to believe, certainly, that because of the, the mining and number of other labor activities, that West Virginians have, traditionally have had a lot of laborious work in the industry. And, as a result, that one can argue that, historically, that could be higher levels of pain related to the work in those industries." You gave that answer, correct?

A. Yes, sir, and that's very different than the question you asked me previously about pain needs.

Q. I was asking you, Dr. Gupta, this question. The laborious work done by many people in this state, mining, heavy labor, that's a factor that can lead to higher levels of pain need, correct?

A. Correct.

Q. Okay, thank you. Let me ask you, also, do you

understand that West Virginia has a relatively aged population?

A. It has one of the more aged populations in the nation as a state.

Q. And that's another factor that can lead to higher pain needs for a population, correct?

A. Mr. Hester, you keep saying "pain needs" and there's a big difference between words, between "pain needs" and "levels of pain". I would -- either you could correct it or I could keep having problems.

Q. Okay. So, maybe we'll go -- we'll try to get on the same wavelength.

A. Please.

Q. That -- and more aged population tends to have higher levels of pain, correct?

A. This is the way I would characterize it. As we age, one could have pain levels that could be higher, generally speaking, than when you are very young.

Q. I think we're communicating. I understand. I hope. I know what you're talking about.

And I think with Ms. Mainigi, you also noted that there is a higher level of disability among the population in West Virginia than compared to the nation, correct?

A. The percent of disability rates in West Virginia are higher than the average U. S. percentage rates.

Q. And people who are disabled in the aggregate may have higher levels of pain; is that correct?

A. That's correct.

Q. And you also talked with Ms. Mainigi about the fact that there's higher levels of obesity in West Virginia compared to the country as a whole; is that correct?

A. That's correct.

Q. And obesity is another factor that can lead to higher levels of pain; is that correct?

A. Not necessarily, but from obesity, if you end up having neuropathy, or disability, or arthritis, that may be a reason that you're suffering from pain, but just by itself, obesity, being obese, many of us are here, shouldn't be causing us pain.

MR. HESTER: Let me ask to put up on the screen from the 2016 deposition of Dr. Gupta Page 69, Lines 20-24.

BY MR. HESTER:

Q. Dr. Gupta, you were under oath again in this deposition, correct?

A. Correct.

Q. Let me read the question that was asked to you in that deposition. "Obesity can cause pain of various types, right?" And your answer was, "It certainly could." And then the next question, "Chronic pain, constant pain?" Your answer, "It could." Do you see that?

A. Yes, sir. My testimony today is a very consistent explanation with this testimony at that time.

Q. But the point is, if somebody -- if there is a level of obesity in a population, that can create greater strains on the skeletal structure of the body, can lead to higher levels of pain, correct?

A. Can I characterize this way? Just -- I just -- I'm just trying to explain, which is in its black and white way, no, but obesity tends to change our body structure over time and we call that potentially sometimes arthritis. Other cases, obesity could lead to cancer. In other cases, it could lead to diabetes, which could lead to neuropathy. So, these are factors, but just pure simple being obese if I'm overweight right now does not cause pain for just itself.

Q. So, other factors come out of obesity that lead to higher levels of pain; is that your point?

A. That potentially could, just like I said in 2016.

Q. And you also mentioned arthritis as another factor for the health of this population in West Virginia, that West Virginia has the highest level of arthritis in the country, correct?

A. That's correct.

Q. And arthritis is often associated with pain; is that correct?

A. That's very correct.

Q. The West Virginia Board of Medicine oversees the practice of medicine in the State of West Virginia, correct?

A. It sees it for MDs, for podiatrists, and for physician assistants. Not for all practitioners.

Q. So, let's focus on the ones that the West Virginia Board of Medicine regulates and the regulation of the West Virginia Board of Medicine, for instance, would extend to general care practitioners, family doctors, primary care physicians, correct?

A. As long as you had an MD, as opposed to a DO, which have their own Board for DOs.

Q. So, the Board of Medicine of West Virginia would be regulating doctors in the state and would issue their licenses to practice medicine; is that correct?

A. For the ones that have MD, yes.

Q. And you're aware that the Board of Medicine from time to time issues guidelines or policy statements that it circulates to doctors in West Virginia?

A. Yes.

Q. And the Board of Medicine over time has issued policy statements relating to the use of opioids in the treatment of pain; is that correct?

A. Yes.

Q. And a doctor practicing in West Virginia should be familiar with the guidelines and policy statements that were

issued by the Board of Medicine; is that correct?
A. That would be correct.
Q. And a doctor practicing in West Virginia should seek to follow the guidelines and policy statements that are issued by the Board of Medicine; is that correct?
A. You are correct.
Q. And are you also aware that the Board of Medicine issues quarterly newsletters to all licensed physicians and physician's assistants in the State of West Virginia from time to time?
A. I'm peripherally aware to the point it comes to my e-mail inbox.
Q. You probably receive them.
A. Yes. It doesn't mean I read them, though, always.
Q. Yes. Let me ask you to look at a document I'm going to show you.

MR. HESTER: May I approach, Your Honor?

THE COURT: Yes.

BY MR. HESTER:

Q. Dr. Gupta, I've shown you a document that's marked as Defendant's Exhibit 3616. It's a quarterly newsletter from the West Virginia Board of Medicine from 2009, early 2009 or I guess -- I'm sorry -- late -- late October, October, 2008 and December, 2008. Have you seen this before?
A. No, sir, primarily because I wasn't in state in

December -- on October of 2008. I had not moved in until March of 2009.

Q. Let me ask you to look at this, the sixth page of the document. Do you see at the bottom of the page there is a heading "Responsible Opioid Prescribing, A Physician's Guide, now available for online purchase"? Do you see that?

A. I see that.

Q. And there's a reference, if you look down into the next paragraph of the document, that it says in the Spring of 2008, the Board of Medicine was able to distribute a book to every licensed physician and physician's assistant in West Virginia, and it's a book written by Scott Fishman. I'm paraphrasing, Dr. Gupta. Do you see that paragraph?

A. I see that paragraph.

Q. And I really wanted to use this as a jog for your memory to see if you remember. Do you remember that the West Virginia Board of Medicine distributed this book by Dr. Fishman on responsible opioid prescribing?

A. Absolutely not, sir, because I wasn't in state and I wasn't licensed at the time, so I would not have received this newsletter, and I would never have read this prior to you showing it to me.

Q. And so, you have never in your -- in your subsequent work in the state, you hadn't heard about this being distributed, the book being distributed?

A. Not to my recollection at this time, but I can certainly not -- I do not remember seeing this document ever before.

Q. All right. Thank you.

Dr. Gupta, am I correct that in recent years there has been an effort to educate doctors in West Virginia to think more carefully about their prescribing of opioids?

A. That would be correct.

Q. And that's something that you've been involved in, correct?

A. That would be correct.

Q. And, for instance, in the 2012-13 time frame, West Virginia established mandatory training for all prescribers on opioid prescribing; is that right?

A. I think we discussed it this morning.

Q. And before that time there was no such mandatory training; is that correct?

A. That's correct.

Q. And I take it over time with more training, more knowledge, better use of the databases that you've discussed earlier today, that doctors in West Virginia in this current time frame are, in fact, writing fewer prescriptions for opioids; is that right?

A. That would be correct. Yes, sir, that would be correct. And, again, to the context of the training,

legislature, Board of Medicine tend to usually do reactionary work, so this was a reaction to the challenge we were facing.

Q. So, there has been a significant decline in the levels of opioid prescribing in recent years, correct?

A. Yes.

Q. Is it correct to say it's roughly a 50% decline in opioid prescribing over the last decade?

A. If we speak specifically about West Virginia, I think there has been quite significant decline. In fact, between 2014 and 2019, in my estimate, there was about 52% decline.

Q. In the levels of prescribing of opioids?

A. Opioid prescribing.

Q. Let me ask you to look at another document that you've discussed before but we haven't gotten it into the record yet.

MR. HESTER: May I approach, Your Honor?

BY MR. HESTER:

Q. Dr. Gupta, I've handed you Defendant's Exhibit 2523. On the front page, it's headed "CDC Guideline For Prescribing Opioids For Chronic Pain, United States, 2016." Dr. Gupta, I take it you've seen this document before?

A. Yes, sir.

Q. And these are the CDC guidelines that you discussed in your testimony over the last two days, correct?

A. That's accurate.

Q. And the CDC published these guidelines in March, 2016?

A. That's correct.

Q. And I -- the way you spoke about them, I assume this is true, but I'll ask you anyway. I assume you've read these guidelines, correct?

A. It's been awhile since my last review, but yes.

Q. And these are the guidelines that you referred to in your testimony yesterday when you mentioned the CDC guidelines, correct?

A. For chronic pain, 2016, yes.

Q. And if you look at Page 2 of these guidelines and, Dr. Gupta, I should explain. There's a lot of numbers on these documents because we're in litigation here. But why don't you work off of the printed number that's really the number of the document, the number that the CDC put on it. So. There's a number 2 there you can see. We can work off of that, okay?

And you can -- let me point you to the right-hand column on Page 2. The beginning of the first full paragraph that says, "This guideline provides recommendations for the prescribing of opioid pain medication by primary care clinicians for chronic pain, I.e., pain conditions that typically last more than three months." Do you see that?

A. I do.

Q. And is that your understanding of what this document was about, that it was to provide guidelines for the prescribing of opioids by primary care clinicians?

A. My understanding was these guidelines were primarily directed at primary care physicians and for chronic pain for opioids, the role of opioids.

MR. HESTER: Your Honor, I move that Defendant's Exhibit 2523 be admitted into evidence.

THE COURT: Is there any objection?

MR. FARRELL: I'm sorry. Are we talking about --

MS. KEARSE: The CDC guidelines.

MR. FARRELL: No objection.

MS. KEARSE: No objection.

THE COURT: It's admitted.

DEFENSE EXHIBIT 2523 ADMITTED

BY MR. HESTER:

Q. Let me ask you to look, Dr. Gupta, at Page 1 of the document. And I wanted to point you to the left-hand column at the end of the first paragraph under background. And there's this last phrase that says the CDC refers to the, quote, "lack of consensus among clinicians on how to use opioid pain medication." Do you see that?

A. I am seeing this as a part of a full sentence.

Q. Yes, yes, yes. I mean, feel free to look at the whole sentence. I just wanted to ask you about that phrase.

A. I read the sentence.

Q. Yes. And when the CDC refers here to a lack of consensus among clinicians on how to use opioid pain medication, when it wrote these guidelines in 2016, that was a correct statement, right?

A. A lack of consensus among physicians is very different than the science and data behind the evidence to support use of opioids for chronic pain. I would have to go back and see their reference because there's one reference here that says in parentheses, too, and I would have to see what type of evidence are they referring to when they make that claim.

Q. So, you don't know whether it's true or not when they refer to a lack of consensus among clinicians about how to use --

A. So, it's not about black and white, I know or I don't believe it or not. It is about evidence. If there is a certain amount of evidence that I can put my weight behind, then I would agree with the statement. If it's referring to one meaning, then I would have trouble agreeing with that.

Q. It refers -- if you look at Footnote 2, it refers to the Palouse article or epidemiological study. Have you looked at that Palouse article before?

A. I haven't recently and I would have to look at that before I can -- because, again, that's a statement based on a reference and I would have to evaluate the reference for

its legitimacy, credibility, as well as validity and science, before I can agree to that.

Q. Maybe we can back up a little bit. When the CDC issues a guideline like this, it's issuing the guideline for the medical community to provide its base of knowledge on how it views the situation at a point in time, correct?

A. That would be correct.

Q. So, this --

THE COURT: Mr. Hester, when you get to a stopping point, we need to switch out the court reporters and it would be a good time to take a break.

MR. HESTER: Yes. I'm happy to stop now, Your Honor, if that's good for you.

THE COURT: Let's be in recess for about ten minutes.

(Recess taken)

BY MR. HESTER:

Q. Dr. Gupta, right before we broke I was asking you the point that the CDC when it issues a guideline like this is providing its view to the medical community on where the state of knowledge lies; correct?

A. This is how I would characterize it. Once CDC issues a guideline on any matter, they're using the best possible available science and data to put together it into a recommendation which are voluntary in nature.

Q. And the purpose of the CDC guidelines is to inform the medical community based on the work that the CDC puts in to develop that insight and guidance?

A. Medical community, the public at large because these are public guidelines, they're not secretive guidelines, to the entire nation.

Q. And, so, for instance, to reflect that point, if you look at Page 3 of the document, at the top of the right-hand column it says, "The guideline is intended to inform clinicians who are considering prescribing opioid pain medication for painful conditions that have or become chronic."

Do you see that?

A. I see that.

Q. So it reflects the point I think you're making that the CDC develops guidelines like this to provide information to clinicians who are considering the prescribing of opioids; correct?

A. That's correct.

Q. So when the CDC said at Page 1, going back to where we were before the break, when it says there's a lack of consensus among clinicians on how to use opioid pain medication, that's the CDC's view based on its study and evaluation of the current state of the science; correct?

A. Not really, sir. That's background introduction. So

what they're saying is here's what exists in literature right now. It would be hard to pin that to CDC because what they're providing you as a nation is here's where we are today. And they are regurgitating whatever they find. It's not -- background is not somebody's view particularly.

Q. Okay. Let me turn you then -- maybe I can make that sharper and make the point a little more clearer if we turn to Page 2.

At the top of the left-hand column there's a sentence that begins -- it's the second or third full sentence on the left-hand column. It begins, "However, it is hard to estimate the number of persons who could potentially benefit from opioid pain medication long-term."

Do you see that?

A. I see that.

Q. And I take it that's the CDC's judgment based on what they've looked at. They concluded it was hard to estimate the number of persons who could potentially benefit from long-term care?

A. That statement would, if you were to characterize it, would mean that CDC does not have a really good estimate of the -- amongst all the people that are suffering from chronic pain as to in what percentage of people you could or could not have benefit from chronic long-term opioid care.

Q. And they go on to say, "Evidence supports short-term

efficacy of opioids for reducing pain and improving function in non-cancer, nociceptive, and neuropathic pain in randomized clinical trials lasting primarily less than 12 weeks." Correct?

A. That's a statement along with two references. Reference does not intend, in parentheses, to cite the evidence.

Q. So there the CDC was concluding that there was evidence of short-term efficacy of opioids for treating chronic non-cancer pain in durations of less than 12 weeks; correct?

A. Durations of less than 12 weeks would not be chronic non-cancer pain. You mentioned chronic non-cancer pain. What they're saying is that -- and I want to read that because it's important.

"The efficacy -- short-term efficacy of opioids for reducing pain and improving function in non-cancer, nociceptive, and neuropathic pain." So they're also saying not all pain, but these two types of pain in randomized clinical trials. That's less than 12 weeks.

Q. And nociceptive means what?

A. What it means where actually you have receptors that actually could react to it. And neuropathic, obviously we've talked about from the nerve involvement and things like that.

Q. So those two phrases together, nociceptive and

neuropathic pain, that's a broad category of pain; correct?

A. Those are two reasons, particular reasons that clinicians might find an opportunity at some level of their management of that patient to prescribe for short-term the pain. And they go on to state when the opioid should be prescribed.

Q. So here the CDC finds that there is evidence to support short-term efficacy of opioids for treatment of these categories of pain in durations of less than 12 weeks; correct?

A. They do that. And the rest of the report, sir, they say it's not first line. It's -- so that's a, that's a statement and it's weighted as a statement only. It's not a finding. It's a statement, a regurgitation of two studies.

Q. Based on their review of all of the scientific evidence that was available at the time; correct?

A. I would generally say so. They would have studied it.

Q. And then the next sentence goes on to say, "However, few studies have been conducted to rigorously assess the long-term benefits of opioids for chronic pain." And then in parentheses they say "pain lasting more than three months."

Do you see that?

A. Yes.

Q. So, again, here the CDC was reporting that the state of

the knowledge at the time based on its review reflected that there were few studies reflecting in a rigorous way the long-term benefit?

A. Yes.

Q. And then I put that together with the statement up above where they say, "It's hard to estimate the number of persons who could benefit from opioid medication long-term."

So putting those together, the CDC was saying there's just not enough science yet to decide what the answer is for long-term pain treatment with opioids; correct?

A. This is the way I would characterize it. What they were saying is that the data on long-term benefits of opioid use is there, but it is not entirely sufficient. And, therefore, these guidelines and that gap would help providers fill that gap in terms of recommendations.

Q. So the CDC was saying there is some data suggesting benefits for long-term pain but it's not clear enough?

A. They're not really saying that in that statement.

Q. But it -- okay. I'll get to it another way. I think we can get to this point another way.

When -- let me point you to Page 2 again, the right-hand column toward the bottom just before "rationale," Dr. Gupta.

You see there's a sentence -- it's the third sentence I think from the bottom of that paragraph before "rationale."

It begins, "Clinical decision-making should be based on a relationship between the clinician and patient, and an understanding of the patient's clinical situation, functioning, and life context."

Do you see that?

A. Yes.

Q. And here the CDC was saying ultimately the decision on using opioids for chronic pain treatment should be entrusted to the decision of a doctor acting in concert with the patient; correct?

A. That's broadly correct.

Q. And they go on at the end of that paragraph to say, "Clinicians should consider the circumstances and unique needs of each patient when providing care."

Do you see that?

A. I do see that.

Q. So the point the CDC was making there is that judgments about whether or not to prescribe opioids for individual patients should be made by the individual doctor taking account of all of the patient circumstances; correct?

A. What they were trying to say was these guidelines are voluntary to help physicians make better, more informed decisions while they're managing their individual patients in a doctor/patient, physician/patient relationship.

Q. And another way to put that might be the decision

ultimately had to be the doctor in consultation with the patient on whether or not to use opioids for chronic --

A. That's --

Q. -- pain?

A. That's true. The decision -- it has to be informed by the best available science and, and it cannot be exclusively by the doctor and the patient without any knowledge of the current science and recommendation that exists nationally.

Q. And that was the purpose for which they issued these guidelines; correct?

A. Yes, sir.

Q. And then if, if we go to Page 17 of the document --

A. Yes, sir.

Q. -- and I think we're on the same page here, Dr. Gupta, but I just wanted to make sure. There's a heading at the right -- at the left-hand side that says "Determining When to Initiate or Continue Opioids for Chronic Pain."

Do you see that heading?

A. I do.

Q. And, so, here the CDC in these guidelines was not apprising clinicians that they should not use opioids for chronic pain; correct?

A. That would be a reasonable conclusion.

Q. The CDC, in fact, was contemplating that clinicians armed with this evidence could decide properly to initiate

opioid treatment for chronic long-term non-cancer pain; correct?

A. The CDC was saying that there are several non-pharmacological options as well as non-opioid pharmacological options available at the behest of the doctor prior to jumping to opioids for the use of chronic pain. And that's kind of what the message here is. But not to say that they should not use it.

Q. Shouldn't -- yeah, that's -- I understand that the CDC was giving guidance to clinicians that they should think about other options too for the treatment of chronic non-cancer pain; correct?

A. Correct.

Q. But the CDC was contemplating that it was appropriate for clinicians armed with sufficient knowledge and information to prescribe prescription opioids for chronic non-cancer pain; correct?

A. The CDC was saying that in certain positions, it is appropriate with certain factors to -- for utilizing opioid therapy for chronic pain.

Q. And that judgment would be left to the doctors armed with knowledge the CDC was providing and in consultation with their patients; correct?

A. That judgment would -- physicians with these specific tools and information and science that the CDC was providing

to, to be able to provide the best, most current care to their patient.

Q. And the CDC guidelines did not suggest any limits on using opioids for the treatment of acute pain; correct?

A. These guidelines were not intended to focus on acute pain.

Q. And the CDC has never issued guidelines trying to limit or add to the base of knowledge around the treatment of acute pain with prescription opioids; correct?

A. There's been a lot of discussions. To my knowledge, no such guidelines have been forthcoming.

Q. And, so, to date, the CDC has not issued any guidance to clinicians to suggest restricting the use of prescription opioids for treating acute pain; correct?

A. I'm not aware of any.

Q. And when we speak about acute pain, we're speaking generally of pain that lasts three months or less; correct?

A. When we're speaking of acute pain in the duration aspect, you might -- you're correct. But also in an individual specific person aspect, we're talking about when you have broken bones, when you have operations and surgery.

So there are circumstances which you need it for -- certainly you need it, but definitely you need it for much, much, much less than three months.

Q. And -- but just to make sure we're communicating with

each other, Dr. Gupta, the CDC has never issued a statement saying you should not use prescription opioids as a first line of treatment for acute pain?

A. I'm not aware of any such statements.

Q. It's also correct, Dr. Gupta, that the CDC did not say in these guidelines that prescription opioids should never be used during pregnancy; correct? I can point you to a page so you don't have to guess.

A. Please point me to the page.

Q. Let's go to Page 26. This, this stood out at me, Dr. Gupta, because of the discussion yesterday around NAS babies. And I wanted to ask you about the discussion. It's at the bottom of the right-hand column on pregnant women. Do you see that?

A. I see that.

Q. And there's a sentence -- it's the third sentence down under that heading where the CDC says, "Importantly, in some cases, opioid use during pregnancy leads to neonatal opioid withdrawal syndrome."

Do you see that?

A. I see that.

Q. And that's what you were discussing yesterday, this problem of withdrawal symptoms for a child or a baby that's exposed in utero to opioids; correct?

A. Yes. We were discussing the, the additional risks to a

pregnant mother in addition to an average non-pregnant individual of which -- one of which was NAS.

Q. But here in the next sentence the CDC recognizes that clinicians and patients together could decide to initiate opioid therapy for chronic pain during pregnancy; correct?

A. That's correct.

Q. So the CDC here was saying you need to weigh risks and benefits in initiating opioid therapy for chronic pain even during the time a woman is pregnant; correct?

A. The CDC is saying that there may be extraordinary circumstances in which chronic opioid therapy might be needed in pregnancy. However, it is even a higher risk than an average person. You should really have a discussion and understand the science behind it before you do that.

Q. And the point I wanted to make is, and it's notable, the CDC did not issue a recommendation saying you should never use opioids while a woman is pregnant?

A. That's correct.

Q. And, again, the CDC was leaving the judgment of whether to use opioids to the decision made jointly by a doctor in consultation with the patient; correct?

A. Correct, in the context of providing all the cautions and evidence and knowledge that they could to the clinicians.

Q. And that was what the CDC was trying to do here was to

flag this issue around the risks of NAS that could be associated with using opioids during pregnancy?

A. Yes, amongst other poor outcomes of pregnancy as well.

Q. Dr. Gupta, let me ask you to look at a document that I think you'll recognize.

Dr. Gupta, I've handed you Defendant's Exhibit 2556. It's headed "State of West Virginia Board of Medicine Policy on Chronic Use of Opioid Analgesics."

I take it you've seen this document before?

A. Yes.

Q. And it bears your signature; correct?

A. It does.

Q. And you were involved in developing this policy on the chronic use of opioid analgesics?

A. I was the Secretary of the Board of Medicine as part of my role as the Commissioner of the Bureau of Public Health.

Q. And, so, as part of that function, you were involved in evaluating whether this made sense as a policy statement for the State of West Virginia?

A. Yes.

Q. And the policy statement was intended to apprise doctors and others involved in prescribing opioids on standards which apply to the use of opioids in the State of West Virginia?

A. It was -- yes, it was Board of Medicine's role that we

were trying to address this.

MR. HESTER: Your Honor, I would move Defendant's Exhibit 2556 into evidence.

THE COURT: Is there any objection?

MS. KEARSE: No objection, Your Honor.

THE COURT: It's admitted.

BY MR. HESTER:

Q. And just to make it totally clear, this was adopted on September 11, 2017; correct, Dr. Gupta?

A. Yes.

Q. And is this the most recent statement that's been issued by the Board of Medicine concerning opioid prescribing for chronic pain?

A. I would not be able to attest to this. I've been out of the system since November of 2018.

Q. You're not aware of any other guidelines that have been issued?

A. There may be some during the COVID period as part of that, but I'm generally not aware of any other guidelines.

Q. And these guidelines apply only to the use of opioids for treating chronic non-cancer pain; is that correct?

A. Let me remind myself.

(Pause)

Yes.

Q. And the guidelines were intended to provide guidance to

the doctors of West Virginia and others who prescribe opioids on the standards they should follow when using prescription opioids to treat chronic non-cancer pain; is that correct?

A. That would be correct.

Q. And the guidelines do not preclude the use of opioids for long-term treatment of chronic non-cancer pain; correct?

A. Correct.

Q. And the guidelines recognize that doctors can properly make the decision to institute or commence opioid treatment for chronic non-cancer pain if they follow the procedures outlined in the guidelines; correct?

A. When it's appropriate, the doctors can do that, yes.

Q. And let me point you in particular to Page 8 of the document. And, again, we can use the numbers on the, on the document itself, not the production numbers.

And I wanted to point you, Dr. Gupta, in particular to the first sentence under "Informed Consent and Treatment Agreement."

And it reads, "The decision to initiate chronic opioid therapy is a shared decision between the clinician and the patient."

Do you see that?

A. Yes.

Q. And, so, again, here it reflects advice from the Board

of Medicine that doctors should make the decision about whether to prescribe opioids for chronic non-cancer pain in consultation with the patient; correct?

A. The statement reflects a shared decision between the clinician and the patient.

Q. And it reflects that the judgment ultimately about whether to prescribe an opioid for any given patient should be made as a consequence of that shared decision between doctor and patient; correct?

A. It's a shared decision, that's correct.

Q. Let me point you to Page 2 of the document, Dr. Gupta.

There's -- it's in the second paragraph on that page. There's a phrase -- and I'm going to read a phrase, but we can look at the whole sentence if you want to, but I want to focus on a phrase. It's the last phrase of that middle paragraph.

It says, "The guidelines recognize the responsibility of clinicians to view pain management as essential to quality of medical practice and to the quality of life for patients who suffer from pain."

Do you see that?

A. I see that.

Q. So here the Board of Medicine is giving guidance to doctors and other prescribers in the State of West Virginia that they should view pain management as essential to the

quality of medical practice; correct?

A. The guidelines are saying -- and I'll just repeat the beginning of it because it's very important in the context of the sentence that these guidelines do not encourage the prescribing of opioids over other pharmacological and non-pharmacological means of treatment but, rather, the guidelines recognize the responsibility of clinicians to view pain management as essential to quality of their practice and the quality of life for patients who suffer from pain.

Q. So -- right. Okay. Thank you. So, in other words, the point is the guidelines were not espousing that one form of pain treatment should be favored over another, but they were highlighting that pain treatment is essential to the practice of medicine; correct?

A. I would alter that a little bit. What the guidelines are espousing is one form of treatment should be favored over the other which is non-pharmacological and pharmacological non-opioid treatment should be favored over opioid treatment. Yet, the importance of managing and addressing pain in a patient is also important.

Q. The guidelines also recognize that, in fact, doctors armed with the proper knowledge could, in fact, properly decide to initiate opioid treatment for chronic non-cancer pain; correct?

A. The guidelines acknowledge that opioids are one of the arrows in the quiver that should be taken out but not the first arrow that should be taken out.

Q. And -- let's follow your metaphor. That's the first time -- when these guidelines were issued in 2017 it's correct that this is the first time there was a statement by the Board of Medicine that prescription opioids should not be the first arrow in the quiver?

A. To my knowledge. My tenure was between 2015 and 2018 on the Board. And I, I -- to my knowledge and recollection, that was the first time following CDC guidelines that these guidelines were issued.

Q. So these guidelines were really a follow-on or were inspired by the CDC guidelines that we've already looked at; correct?

A. Yes.

Q. The guidelines also make it clear that they're not intended for the treatment of acute pain, management of pain in the perioperative setting, emergency care, cancer related pain or palliative care, end of life care; correct?

A. If you could point me to the page.

Q. Sorry, my apologies. It was the next paragraph down. I had meant to point you there, Dr. Gupta. I forgot.

A. That's what it says, yes.

Q. So, in other words, the guidelines that were issued by

the Board of Medicine in 2017 only focused on using prescription opioids for chronic non-cancer pain treatment; correct?

A. Correct, because that's where the most volume of the prescriptions were coming from.

Q. The, the guidelines were not intended to affect the decisions that doctors were making in other settings in using prescription opioids; correct?

A. The guidelines were intended generally to inform the decisions the doctors were making over all the context of opioids, but they were not specific to acute pain and other settings as you've highlighted.

Q. And, and, so, the Board of Medicine has never issued guidelines to doctors in West Virginia suggesting any limits on the use of prescription opioids for the treatment of pain in settings outside chronic non-cancer pain; correct?

A. The Senate Bill 273 which the Board of Medicine of West Virginia and all the prescribing, boards of prescribers are required to follow the state law. So that term -- I would say that to the extent that the Senate Bill 273 requires that certain prescription narrowing of that, that, that has happened. But beyond that, the Board of Medicine has not, in my knowledge and memory, has issued any such other guidelines.

Q. So there was not an intention through these guidelines

to alter doctors' practices in relation to the use of pain outside chronic non-cancer pain; correct?

A. That would be accurate.

Q. Let me ask you to look at -- do you have the exhibit from your direct examination up there, Dr. Gupta?

A. Yes.

Q. So I wanted to have you look back at Plaintiffs' Exhibit 44223.

A. I have it.

Q. And this is the January, 2018, Opioid Response Plan that you commissioned; correct?

A. Correct.

Q. And I'd like to review some passages from this document which you didn't have a chance to discuss yesterday with Ms. Kearse.

Let me ask you to look at Page 4, Dr. Gupta.

A. I'm here.

Q. And it states -- and I wanted to point you to the middle of the, middle of the paragraph under "Background." I'm trying to find it. Okay.

The second sentence begins, "Initially, the overdose death increases were driven by pharmaceuticals, first methadone, which was prescribed for pain, and then oxycodone, hydrocodone, and oxymorphone."

Do you see that?

A. Yes, I do.

Q. And then if you go two sentences down, it says, "In 2012 just as prescriptions for opioids were beginning to decline, a major shift from pharmaceuticals to illicit drugs began."

Do you see that?

A. I see that.

Q. That's a true statement; correct?

A. That's a true statement in the context of the other statements that are also listed there.

Q. And then the, the next sentence reads, "The shift began with heroin in 2012 and then shifted to fentanyl and fentanyl analogues alone or in combination starting in 2014."

Do you see that?

A. I see that.

Q. And that's a true statement; correct?

A. That would be accurate.

Q. And the reference there to fentanyl and fentanyl analogues are two illicit analogues that were being used by drug dealers; correct?

A. The reference for both heroin, fentanyl, and fentanyl analogues alone or in combination is for non-prescriber drugs.

Q. Or what we might call illicit drugs or illegal drugs?

A. Drugs that were not prescribed.

Q. I was just trying to make sure we were on the right phraseology. These are illicit fentanyl or fentanyl analogues; correct?

A. Yes.

Q. And I guess we can see that -- I could have answered may own question with the next sentence. "The fentanyl driving the unprecedented increase in deaths is illicitly sourced and generally not of pharmaceutical origin."

Do you see that?

A. Yes, I see that.

Q. And that's the point you just made; correct? These were, these were illicitly sourced fentanyl derivations; correct?

A. That's exactly why I said non-prescriber drugs there, yeah. That was my point.

Q. And, so, that's a true statement, that the fentanyl driving the unprecedented increases in deaths was illicitly sourced; correct?

A. Yes, that's a true statement in the context of most of the time when people die from fentanyl, which is, I'm sure the Court has heard, much more potent, is in combination with heroin. It's not the heroin but the fentanyl that kills them. That's my point.

Q. And the point you're making there, Dr. Gupta, is that

drug dealers often will spike or adulterate heroin with fentanyl; correct?

A. Yeah, they call it on the street cut, cut the heroin with fentanyl. So they could, they could be less -- it could be cheaper to them. They can make more money off of it.

Q. Cheaper because the fentanyl is cheaper than the heroin. And, so, if they adulterate the heroin with fentanyl, it's cheaper for the drug dealer?

A. So the fentanyl is a lot more potent, so you have to use much more smaller amounts and you have to use heroin in it. So if you cut it with fentanyl, you can save a lot of cost of heroin. So that's exactly right.

Q. And the, and the fentanyl is, is typically -- the illicit fentanyl in the country now is typically sourced out of China and illegally smuggled to the U.S. Is that your understanding?

A. My understanding is there are foreign nations that are responsible for, for fentanyl in this country.

Q. And then, and then often times users may not even be aware that a drug dealer has cut or adulterated the heroin with fentanyl. The drug dealer might be doing that to save cost without even telling the user. Correct?

A. That's the tragedy of all of those deaths as well.

Q. Let me ask you to turn to Page 7 of the document. I

wanted to point you toward the bottom of that page under "Data and Evidence."

A. Okay.

Q. There's a first sentence that reads, "A critical factor fueling the national opioid epidemic is the rapid rise in opioid prescriptions for pain."

Do you see that?

A. Yes.

Q. And that's a true statement; correct?

A. Correct.

Q. And those are the decisions on opioid prescriptions that we've discussed before that were being made by doctors; correct?

A. The meaning of the statement is the total volume in communities resulting from these prescriptions is resulting in a lot of spreading or diversion of that, those prescriptions and pills across populations that did not intend to take those medications or they were not prescribed for. So that's the meaning of that.

Q. But the, but the first point is when it refers here to prescriptions, these are prescriptions being written by doctors; correct?

A. That, that would be the -- these, these pills that are out there legitimately or illegitimately are coming out of pharmacies from prescriptions that are coming out of offices

of prescribers.

Q. And then I think this is the point you were just making, Dr. Gupta. Let's look at the top of Page 8. It says, "Excessive prescribing can lead to substance use disorders directly, as the risk of developing such a disorder increases with higher doses for longer durations, or indirectly, as extra pills are provided to or stolen by others."

I think that's the point you were just making; correct?

A. Yes, that's exactly the point I was making.

Q. And, so, let's, let's break that down into two halves.

First, it refers to excessive prescribing that leads to substance use disorders directly. That's somebody taking pills under a doctor's instruction who over time develop a substance use disorder because they've taken it for too long or in too high a dose; correct?

A. So the prescribing of this could happen because of good doctors and bad doctors. And when bad doctors keep prescribing high doses for a long time to people unnecessarily, for that first part of the discussion, substance use disorder can develop in those people as well.

Q. And there can also be circumstances where a good doctor is trying to make good decisions but mistakenly leads somebody into a substance use disorder because they've given them too high a dose for too long; correct?

A. That would be much rarer as opposed to a pill mill situation where a lot of bad doctors can produce a lot of prescriptions in a short amount of time. And that could overflow in volume to a lot of people, including their patients. And they could -- all of them could end up becoming -- suffering from substance use disorder.

Q. When, when you use this phrase "directly" here, you mean people who are getting prescription opioids via a prescription and using them, they're prescribed pills, correct, whether by a legitimate doctor or a bad doctor?

A. Correct.

Q. Then "indirectly." I want to take the second half of the reference here. You refer to "indirectly." And it -- again, to put it in context, excessive prescribing leads indirectly to problems as extra pills are provided to or stolen by others.

And the point you're making there is the doctor might have a legitimate reason to prescribe a certain number of pills, but prescribes many more, gives too many pills and they end up in the medicine cabinet and get stolen or sold or borrowed by somebody else. Correct?

A. Yeah. I can explain this really because I've lived this.

So you could have good doctors. You could have bad doctors. The good doctors could prescribe adequate

prescriptions or more than adequate prescriptions.

And in a good doctor case, which is less common, but if you prescribe for a tooth pull 30 days worth of opioids at a dentist, then those -- 29 days of that opioid is going to sit in your closet. And your kids are going to get their hands on it or somebody else is going to get their hands on it.

The bad doctors are writing regularly and habitually a large amount of prescriptions regardless of condition. And those are primarily going to -- for people who don't need them and were not prescribed.

Q. But either way, they're coming from a doctor, either a good doctor who's writing a prescription and including too many pills in that prescription or a bad doctor who's willy-nilly sending out pills by prescription; right?

A. That's correct.

Q. And, so, let's focus on the good doctor. So the good doctor who extracts -- well, I guess it's not going to be a doctor. A dentist who extracts a tooth or a good doctor who treats somebody who's got an ankle sprain and they give 30 days of pills when two days were necessary, those were judgments being made by the doctors, correct, about how many pills were warranted?

A. So the good doctor who writes a thirty-day prescription to a high school football injury, a kid for 30 days who

didn't need it is someone who's writing that, that decision is being made in context with the doctor and the patient together.

However, it's influenced by a lot of other factors like ultimately the judgment and decision is made by the doctor, but the influence of that goes beyond just the physician, just -- or just the prescriber.

Q. But the point I wanted to make is there, there was a standard clinical practice for a number of years in West Virginia and elsewhere to write prescriptions with too many days of pills; correct?

A. I don't know if it was standard practice but, yes, the culture was of -- typically would be that if you got a, you know, a kid got a football injury or a tooth pulled, you would easily write several more days of prescriptions than you would require or evidence would suggest that you would need.

Q. And, so, -- and, and that's the point made here in this document, extra pills. When you refer there to "extra," you're talking about pills that weren't needed to treat the pain for which they were prescribed; right?

A. So, so any pills that are used for any purpose other than specifically for reasons are all illegitimate pills. And that's part of the diversion.

Q. But you could have a good doctor who writes a perfectly

legitimate prescription for a knee sprain, but writes for too many days; correct?

A. Correct. And all of those extra days are illegitimate prescriptions and illegitimate dose and leads to diversion.

Q. Yeah. Maybe it's just this word "legitimate" or "illegitimate," but it's a, it's a medical judgment that's appropriate. The doctor might appropriately decide somebody needed some pain pills for a knee sprain, but the doctor gave too many days in that prescription; correct?

A. Yeah. It's, it's, it is possible. It's probable for a good doctor to make a good sound judgment for the need of opioids, but make a mistake on the duration of the need of opioids.

So instead of three days, you write for 30 days, that's a problem. And not everybody who does that is necessarily a bad doctor or bad prescriber. That's what was happening.

Q. That was a common mistake in the medical profession; correct?

A. It was. It was a behavior. It was a culture.

Q. It was a culture of writing too many days of pills for a given need; correct?

A. A culture of attempting to reduce pain from a scale of whatever to zero for every American, every West Virginian that they could possibly do.

Q. But I'm focusing particularly on this point about the

culture of writing more days than was needed. If the kid has a high school knee sprain, the kid's not going to need 30 days of pills, but the doctors were often writing 30 days of pills; correct?

A. So, Mr. Hester, you have to look for the intent behind that. What's the intent of a good physician? Physicians don't go through medical school, residency, Board of Medicine, license to hurt their patients.

So the intent here was because the belief was you have to bring the patient down from whatever level to zero. So intent was good for good doctors. Yet, because of that intent, they perhaps wrote for longer than they should have written for.

Q. And now what we ended up with is a whole series of these. We take all those prescriptions that were written by all these doctors that were for too many days, and what we end up with in the aggregate is a lot of pills that are in medicine cabinets or drawers of people's homes and they end up then out in the community; correct?

A. So all of these prescriptions -- and, and I go back to the pill mills and bad doctors because that's where the volume is. It's going on and they were all going to the pharmacy and they were all being brought in and they were dispensed and that's exactly where they end up as you stated.

Q. Let me ask you to look just a little further down on this same page. It's in "Discussion and Recommendations."

And there you say in the first sentence, "The most promising approaches to opioid prescribing combine education and tools for all prescribers with an enhanced enforcement for the relatively few prescribers who are violating standards of care."

Do you see that?

A. I do.

Q. And I think this is exactly what we were talking about, Dr. Gupta, but let me just confirm it.

When you talk about a promising approach to address opioid prescribing is education and tools for all prescribers, that was to address the problem of the good doctor who was writing for too many days; correct?

A. Correct, and, and also make sure that the bad doctors were understanding that these tools and other things were available as well.

Q. Exactly. So for all doctors, the point was educate them more that if you've got a kid with a high school knee injury, don't send him home with 30 days of pills. Send him home with a fewer number of days of pills. Correct?

A. We believe if we can help educate doctors and other prescribers and provide those tools, especially in terms of the best knowledge in opioid prescribing, it would help make

a dent in the entire volume problem.

And then we'd be left with the bad doctors and we would have to obviously -- the second statement, part of the statement says "enhance enforcement." It would help us get better control over the bad doctors.

Q. But let's keep focusing on the good doctors. I haven't asked you about the bad doctors. But on the good doctors, you've actually seen this play out, haven't you, that this thinking that you have has led to a significant reduction in opioid prescribing levels in West Virginia because doctors become better educated. Correct?

A. I would say amongst a number of other factors. Clearly, the education, the tools have been helpful in reducing and changing the culture of, of writing large prescriptions, high dose for long periods.

Q. Let's talk about the second half. There's a reference to enhanced enforcement for the relatively few prescribers who are violating standards of care. Do you see that?

A. Yes.

Q. So when you say there are relatively few prescribers who are violating the standards of care, your point is most prescribers thought they were doing the right thing with the standard of care at the time and there were relatively few who weren't?

A. Yeah. There were more prescribers trying to do the

right thing than those who weren't, meaning in West Virginia there were more good doctors than bad doctors at any one point in time.

Q. Most of the doctors thought they were doing the right thing. As you said, they were sending somebody home trying to treat their pain. They thought they were doing the right thing, but they were giving too many pills.

A. Their intent was to help their patient because that was the culture. That was the education. That was the influence. That was their understanding.

Q. And, and you and others in the State of West Virginia have worked on changing that culture of prescribing behavior to tighten it up; correct?

A. We have tried to do our best.

Q. But -- again, at the end of the day, you ultimately have to rely on the good judgment and thoughtful approach of individual doctors to get prescribing under control; correct?

A. Yes, but there's a number of factors that influences that judgment.

One of those things we did in Bureau of Public Health was we began something called counter-detailing. This is, this is our folks going to doctors' officers and providing them this education and tools, knowing there was already detailing happening that was telling them the other way

around for years.

So one of the things we would do is academic detailing. So instead of pharmaceutical detailing, we were doing academic detailing. That's actually a term. And we were doing that because this was part of the education, as we discussed, to get those doctors to understand the science, the evidence. It was a tool they need to be able to more judiciously prescribe opioids.

Q. That was a statewide program you ran?

A. Yes.

Q. And did it help?

A. We believed so.

Q. And the way it helped was doctors then had more knowledge about imposing reasonable limits on how many days of prescriptions they would write?

A. We were sharing the best practices, science that was available with doctors attempting to get them to take the best possible care of their patients with, within safety and efficacy, safety from opioids and understanding addiction but, at the same time, understanding that here are all these non-pharmaceutical options. Here are all the pharmaceutical non-opioid options. And then you think about opioids.

Q. And then going back to the relatively few, the other side of the coin, the relatively few prescribers who were violating the standards of care, it's only been a handful of

really bad doctors in this state who drove a lot of volume; correct?

A. There have been shut-downs of these pain pills, but they had a tremendous lot of volume that was going through. And those shut-downs, as I've stated before, has led to a lot of that transition of people from pills to heroin.

Q. I wanted to ask you just about the shut-downs, though. How many were shut down?

A. I don't have an exact number. I do know that there have been several.

But one other important thing also I want to mention is because we're a border state, we're not a state by itself, we have other states. And when those shut-downs happened, the people that live in West Virginia, it affects people because some of our people have been not only within state but they were going out-of-state to get these. So the shut-down affects not just the ones in West Virginia but also in contiguous states.

Q. So it needs to be a multi-state process to deal with issues of the opioid crisis?

A. It is certainly a national crisis, as we discussed. West Virginia is at ground zero.

Q. The -- you said it's -- you're only aware of a handful of doctors who are violating the standards of care?

A. I don't have exact numbers, but what I would say to you

is, is there's a faction of doctors who we disciplined at the Board of Medicine. There's another set of doctors who -- and businesses with pill mills were shut down legally.

And when that information comes to our knowledge, both at the Board of Pharmacy as well as the Board of Medicine, we do take action.

Q. And, and can you think of any in recent years or is this back more in time?

A. I don't have any in recent years to speak of.

Q. Most of what you're talking about with shutting down doctors was back a number of years; correct?

A. During my tenure is when I'm talking about.

Q. All right. Let me ask you, Dr. Gupta, to look at Plaintiffs' Exhibit 41913. This was the White Paper, the Need for Harm Reduction Programs in West Virginia. Do you have that one?

A. Yes, sir.

Q. I, I have just a few simple questions on this. You'll recall discussing this document yesterday with Ms. Kearse?

A. Yes.

Q. And this Harm Reduction Program is one that's focused on persons who inject drugs; right?

A. Yes.

Q. And, so, I wanted to make sure we knew where, where the

focus is for a program like this on harm reduction.

So it's -- this is exclusively dealing with people who inject drugs?

A. Yes.

Q. And, so, that would include heroin users or people who are abusing prescription opioids by crushing them and injecting them?

A. Yes, or, or meth or other substances. The idea here of a Harm Reduction Program is to, you know, set up several strategies that I mentioned yesterday.

One of those were to provide people clean, free syringes so they are not at risk of spreading infectious diseases.

Another one is to make sure they screen for hepatitis and HIV. Another one is to give them immunizations, the shots, so they don't develop disease. Another one is family planning. And another important one is make sure that people are connected to help to get treatment.

Q. But, but in particular, I wanted to say that in relation to anybody who's using prescription opioids, these would be people misusing prescription opioids who would be covered by this program; correct?

A. In the context of what we discussed, these are the people who were illegitimately using prescriptions or using non-prescribed medications.

Q. Because they would be -- for instance, with a prescription opioid, they would be crushing or otherwise turning it into a powder that they could then inject; correct?

A. Yes, sir. And that would be illegitimate use of prescription pills.

Q. Let me ask you to look at your 2016 Overdose Fatality Analysis. It's Plaintiffs' Exhibit 44211. Do you have that one in your stack?

A. Yes, I do.

Q. Let me ask you to look at Page 8, please.

A. I'm here.

Q. And there's a sentence -- you may have talked about this yesterday. I'm not sure. But there's a sentence that says -- under "Overdose Trends in West Virginia" about four sentences down, it says, "Approximately 705 (85 percent) of the overdose deaths that occurred in West Virginia were opioid related."

Do you see that?

A. I see that.

Q. And I just wanted to clarify as a matter of phraseology, when you refer in this paper to opioids, you're talking about heroin, illicit fentanyl, prescription opioids that are being misused. That's all within this opioid phraseology. Correct?

A. Correct.

Q. If you could look at the next page, Page 9. And, again, I think this is, this is easy given what we've discussed, but I just wanted to make it clear.

There's a paragraph that begins, "Since 2014 the percent of overdose deaths in West Virginia involving fentanyl or fentanyl analogues has increased tremendously from nine percent of overdose deaths involving fentanyl or fentanyl analogues to 41 percent of overdose deaths in 2016."

Do you see that?

A. I see that.

Q. And that's a correct statement?

A. That's a statement -- correct statement, and it's in the context of we're finding most that fentanyl or fentanyl analogues as part of heroin, which that trend, as we discussed, went from 2012 to 2013. So just to add, the 2012 to 2013 trend, heroin, and then from 2014 we started to see fentanyl come into it.

Q. And this is the illicit fentanyl we've been discussing that's used to cut or adulterate heroin?

A. Yes.

Q. And then further down in that same paragraph there's a reference to a cluster of non-fatal overdoses that occurred in August, 2016, in Cabell County. Do you see that?

A. I see that, yes.

Q. And that's the, that's the cluster investigation that you discussed yesterday with Ms. Kearse; right?

A. Yes.

Q. And here it indicates that there was evidence that a high-potency synthetic opioid had entered the local illicit drug supply and contributed to these overdoses; correct?

A. Yes, carfentanil, which we also know as elephant tranquilizer. That was one.

Q. So that's the, that's the -- fentanyl or carfentanil, that was the drug that led to that cluster of overdoses in August, 2016?

A. That three cases out of the total of 20 cases in that one particular overdose.

Q. Well, in the prior sentence it says a high-potency synthetic opioid had entered the drug supply contributing to 20 persons overdosing within a 53-hour period. Do you see that?

A. I do see that. And following that it says three cases were positive for carfentanil. So what we could find was three cases out of 20.

Q. But then the rest, the rest of that cluster was attributed to some other high-potency synthetic opioid; correct?

A. Yes, and that fentanyl is included in that.

Q. So the carfentanil is even more potent. It's used to tranquilize elephants?

A. Yes. And we put that three people there because pleasantly we were kind of surprised that they didn't die because carfentanil, you don't live to tell about it generally.

Q. It says here in the paper it's estimated to be 10,000 times more potent than morphine; is that correct?

A. That's correct.

Q. And, so, carfentanil is being used by drug dealers to adulterate heroin?

A. We have seen evidence in spotty places. It's rare, but we are seeing elephant tranquilizers at occasional places show up.

Q. Let me ask you to look at Page 10 of the document, please. This is discussing maternal drug use and Neonatal Abstinence Syndrome. Do you see that, that section?

A. Yes.

Q. And we, we've talked about this a little bit already in relation to the CDC guidelines. But I wanted to make clear how NAS occurs. And, again, as we were discussing, NAS is something that afflicts a baby who's exposed to opioids in utero; correct?

A. Yes.

Q. And am I right, Dr. Gupta, that there's two ways that

that could happen? One way is a doctor prescribes opioids for a medical purpose during a woman's pregnancy; correct?

A. Yes.

Q. The other way is a woman is misusing prescription opioids for a non-medical purpose not under doctor's instructions during pregnancy; correct?

A. That's one of the, one of the second ways and -- yes.

Q. Those are the only two ways that NAS would occur; correct? Either the doctor has instructed that opioids be used, even though the woman is pregnant, or the woman is misusing opioids during pregnancy?

A. With relation to prescription drugs, yes.

Q. So that -- there's no other way that NAS occurs. The baby has to be in utero during the time the woman is using the prescription opioids; correct?

A. In relation to prescription opioids, that's correct.

Q. And in relation to illegal drugs, it sounds like you're drawing a distinction. You're suggesting that NAS could occur for a baby through an illegal drug even if the woman isn't using the illegal drug during pregnancy?

A. Certainly, NAS is basically a withdrawal. What the baby -- so when the cord is cut, you separate the baby from the mom. And just like an adult, if you were to stop somebody who was using substances every day, they would undergo withdrawal because of the dependency. So does the

poor baby.

And, so, that withdrawal can happen if the mother was using prescription opioids, if the mother was using illegitimately prescription opioids, or the mother was using illicit opioids, knowing that heroin is also an opioid.

Q. Right. So, so the point is when we see a baby with NAS, that NAS could have resulted from the mother using heroin during pregnancy; correct?

A. Technically you're correct. But what we saw in West Virginia was that the increased use of prescription opioids were not exclusively to non-pregnant people.

So with increased use of West Virginians for opioids, we also saw a parallel increase in pregnant people with opioids as well. So we saw that trend happen.

Q. And, again, just to make it clear, the NAS would occur, that increase would occur either because the woman was misusing prescription opioids during pregnancy or a doctor had told the woman to use prescription opioids during pregnancy. That's the way it happens.

A. Or illicitly or a combination of all of those, so two more things on there.

Q. And, of course, when a baby has NAS, we don't know where the mom sourced the opioid. We don't know whether it was an illegal heroin. We don't know if it was an illicitly trafficked prescription opioid. We don't know where it came

from. We just know the baby has been exposed to an opioid.

A. We know because we are able to then match that mother with the Controlled Substance Monitoring Program and see what she was prescribed. So we are able to tell that.

Q. But there will be -- there's a number of cases, I take it, that you've seen where the baby has NAS but the mother was not prescribed an opioid during pregnancy?

A. That would be the part of the diversion of those prescriptions or illicit use, but that does exist.

Q. And is the percentage of, of babies with NAS more attributable to women who have been told by a doctor to use a prescription opioid during pregnancy or to women who are misusing prescription opioids that have been diverted?

A. So as you mentioned that only a certain percentage of women that are using substances will the kids of theirs develop NAS.

What we found is about 14.7 percent of women had a positive uterine test for a controlled substance. And, of course, only five percent developed NAS.

So NAS is one that's not a one-to-one relationship with use. But -- so it's very hard to say that this percentage is because of that because what we do see is overall, the number of pregnant people using prescriptions, whether legitimately or illegitimately, went up relatively proportionally to the general population.

Q. Your, your expectation is that most of the NAS that you've seen would be the consequence of misuse of prescription opioids by women who are pregnant?

A. Use or misuse.

Q. It would have to be one or the other; correct?

A. In most cases.

Q. Let me ask you to look at Page 33 of this document, please. And I wanted to point you, Dr. Gupta, to Figure 20 at the top of Page 33. This shows drug category by decedent age group. Do you see that?

A. I see that.

Q. And, so, where we -- if we look -- let's just focus on a column. Let's look at the 25-to-34-year-old column. And it shows that the illicit use is the blue bar, the one at the bottom. And then there's an Rx only and then there's a multi-category. Do you see that?

A. Yes.

Q. And, so, when it says "illicit only," that would mean that these were decedents who only had an illicit drug in their system at the time of death?

A. That's correct.

Q. And that would be heroin or fentanyl or some other illicit drug; correct?

A. Correct.

Q. And then the Rx only, that would, that would be

referring to somebody who had a prescription opioid in their body at the time of death; correct?

A. That would be correct.

Q. But we would not know from looking at the decedent, we wouldn't know whether they sourced that from a drug trafficker, whether they had taken that prescription opioid out of somebody else's medicine cabinet, or bought it on the street. We wouldn't know. All we can tell is that they have a prescription opioid in their system; correct?

A. That's correct except that at the beginning of the report I think somewhere we said in the decedents, I think it was 36 percent, but almost a third of decedents had prescription drugs in their system but didn't have a prescription for it. So we do have a broad understanding of diversion.

Q. But, but somebody could have a prescription for prescription opioids but might have overdosed by buying a whole bunch of additional opioids on the street; correct?

A. That's possible.

Q. So you can't really tell from whether somebody has a prescription whether they -- if they, if they took 20 prescription opioids and died, they might have gotten 19 of those on the street and one from a doctor. Correct? You just can't tell.

A. Yeah. And that kind of goes back to the behavior and

the pattern. The pattern is that those individuals would have a likelihood of using, you know, the doctor's prescription, the street prescription, and multiple other things.

Q. And, so, the point is we can't tell from looking at when it says Rx only here, this small little orange bar in the middle, we can't tell whether that's, in fact, a legitimate prescribed opioid that led to a death and, in fact, the likelihood would be it's misused opioids. Correct?

A. It, it could be, but there's no way to prove one from the other, as you stated.

Q. And then the, the gray bar at the top, that's multi-category. That means it's, it's multiple, different kinds of drugs. And as you pointed out yesterday, the average is over three different drugs that are found in decedents at the time of death; correct?

A. Correct. And that could include, once again, the Rx. So that could include prescribed drugs as well.

Q. So if we add it up, I, I tried to figure this out. It looks to be 95 percent in that 25 to 34 age group. 95 percent either had multiple drugs in their system at the time of death or only illicit. Correct?

A. That's what it about seems like.

Q. Let me ask you to go to your Historical Overview, the

Plaintiffs' Exhibit 41213, please. I just have a few questions on this, Dr. Gupta.

If you could look at Page 3 of this document. And this shows the drug overdose maps that you discussed with Ms. Kearse yesterday; right?

A. Yes.

Q. These maps are not limited to prescription opioids; correct?

A. These are not limited to prescription opioids, correct.

Q. So these are, these are, in fact, all drug overdoses from any kind of drug; correct? Cocaine, methamphetamine, prescription opioids, heroin, fentanyl, all of them are included; correct?

A. Correct.

Q. And they would certainly include people who have overdosed on heroin or carfentanil or anything else; correct?

A. Correct. And that's why it's important to understand the trends over time, not one particular area, but over time what happened because some of these things transition from one to the other.

Q. The, the -- let me ask you to look at Page 3 in the first paragraph.

A. Page 3?

Q. Yes, same page. We don't have to move. And there's a

sentence that says, "In 2015 there were 5,000 opioid deaths attributed to powerful synthetic opiates (fentanyl) creating an increase of 75 percent from 2014."

Do you see that?

A. Yes.

Q. And that's what we've been discussing. That's typically going to be an adulterated heroin that's been adulterated with fentanyl; correct?

A. Correct. And, and this is at a national level that we're reading out. And what we're seeing is the very same thing we've been talking about. In 2012, 2013, a trigger happened to heroin. And in 2014 almost we had started to see increases in contamination of that heroin with the synthetic opioid called fentanyl which is much more potent, much more deadly.

Q. And is it your understanding that the spike in heroin that you started seeing in 2012, 2013, one factor in that spike was that there was an increased purity and a reduction in price of heroin in West Virginia?

A. You said increased purity and reduction in price?

Q. Both.

A. So in any market in illicit, the price depends on demand. So, so the point becomes that demand and supply are very important factors. So the purity is obviously controlled beyond those elements. But the price is usually

dependent on what the demand is.

Q. But I wanted to ask you specifically, are you aware that in 2012, 2013 there was a, an increase in the purity of heroin in West Virginia?

A. I'm not aware that there was -- specifically in that year it was much more pure than previously, but I'm aware generally around that period that there was purity, increased purities of heroin.

Q. And, and were you also aware that the increased purity was accompanied by a reduction in price in heroin in West Virginia? Were you aware of that?

A. By the fact we were seeing people transition to cheaper alternatives readily available, we surmised that it is much cheaper at the time, heroin is, as opposed to --

Q. I was asking about the price of heroin.

A. Yes, yes.

Q. You knew the price of heroin had declined?

A. I wasn't aware acutely that the price in 2012, '13 had declined. I'm not aware of that specifically. I'm aware generally.

Q. Generally that the price of heroin had gone down?

A. Generally, price is affordable as opposed to purchasing prescription pills on the market.

MR. HESTER: Move to strike, Your Honor. I just asked the witness about the price of heroin.

THE COURT: Just try to answer the precise question, Dr. Gupta.

BY MR. HESTER:

Q. So you're aware that the price of heroin has been reduced while the purity of heroin has increased in West Virginia over the last number of years?

A. Yes.

Q. Let me ask you to turn to Page 5 of this document, please, Dr. Gupta. And, and this is a chart I believe you discussed yesterday with Ms. Kearse, Figure 3. Do you see that?

A. Yes.

Q. And I wanted to confirm again, just like the CDC maps we were looking at on Page 3, this is not limited to overdoses of opioids; correct?

A. Correct.

Q. It includes overdoses from all drugs?

A. Correct.

Q. And that would include illegal drugs such as heroin and illicit fentanyl as we've been discussing?

A. Correct.

Q. And then let me ask you to look at Figure 8, Page 7. This is another table you discussed with Ms. Kearse yesterday; right?

A. Yes.

Q. And this again is, is relating to all drug overdoses in West Virginia. It's not confined to opioid overdoses. Correct?

A. This particular figure is.

Q. It's headed "Total Drug Overdose Deaths by Range." This is not -- this is all drug overdoses; correct?

A. Yeah, this particular one is, yes.

Q. Okay. Thank you. That's what I thought. I just wanted to confirm. So it includes deaths from cocaine, methamphetamine, other drug overdoses aside from opioids?

A. Yes.

Q. And it would also include heroin and illicit fentanyl overdoses; correct?

A. This would include all overdose deaths, this particular one.

Q. Let me ask you to look at Figure 11 which is I think on Page 10. So this one is headed "Oxycodone Related Overdose Death." Do you see that?

A. Yes.

Q. And this would include people who at the time of death had multiple drugs in their system, one of which was oxycodone; correct?

A. This particular figure talks about only oxycodone related overdose deaths.

Q. Well, is it sourced, is it sourced from the table from

the same West Virginia death certificates you've discussed previously in the report?

A. Let me look at that.

(Pause)

So you would have to add up the years for oxycodone, 2012, 2013, 2014 and 2015. So I'm going to do that to make sure those are right.

Q. Let me make sure I know what you're doing. Are you looking at Table 1, the oxycodone line in Table 1?

A. Yes. And we should be able to add the four years from 2012 to 2015. That number should come to 755. And if that's the case, then that's appropriate.

Q. But I'm not saying it's appropriate or inappropriate. I just wanted to make sure we knew what we were looking at.

The Table 1 where people who have oxycodone in their system at the time of death, they could also have other drugs in their system at the time of death; correct?

A. They potentially could, but these are the opioids recorded on the West Virginia death certificates for those individuals.

Q. No, but look at the paragraph above Table 1 explains that --

A. Yes.

Q. This reflects people who might have multiple drugs in their system at the time of death. And it lists oxycodone

if that was one of the drugs in their system. Correct?
A. Yes, they could. My response is they could, but it does not mean they did always.
Q. But the point I'm trying to get to is that Figure 11 where you're showing these deaths by age range, that's going to include people who had other drugs in their system, heroin, fentanyl, as well as prescription opioids at the time of death. It includes those numbers.
A. So, so I just, for the Court's understanding, when we state on death certificates this particular oxycodone as opposed to heroin, it is a clinical judgment of the Office of the Chief Medical Examiner that the cause of death was oxycodone. Now, --

MR. HESTER: Move to strike, Your Honor. That's not responsive to my question.

MR. FARRELL: Your Honor, if I may.

THE COURT: Mr. Farrell.

MR. FARRELL: I think it was exactly responsive, Your Honor.

THE COURT: Well, I think he was explaining his answer. I'm going to let him go ahead.

THE WITNESS: So just trying to explain, so the Chief Medical Examiner in the state has to make a decision ultimately what is the responsible cause on the death certificate because it has its own consequences.

So those are the causes. These people can have -- they could have other substances found.

So when we take that and look at the oxycodone for the -- from 2012 to 2015, that's what you're seeing on Figure 11.

So to answer your question, theoretically they could. I'm not opposing that at all. But the predominant cause of death are these substances, the oxycodone.

BY MR. HESTER:

Q. Well, let me look -- let me ask you to look at Page 8. At the top of the page above Table 1 there's a sentence that reads, "Due to the fact that most drug overdose deaths involve multiple substances, (polypharmacy) any individual death may involve multiple types of drugs."

Do you see that?

A. That's accurate.

Q. And you agree with that; correct?

A. Yes.

Q. And then in the table there's a specific point made that the bottom number doesn't add up to the, to the -- because you could have multiple drugs in somebody's system at the time of their death; correct?

A. Yes, Mr. Hester. We still have to at the end of the day make a decision: What killed the person. You can have

three things, four things, but you still have to figure out what caused the ultimate death. And this is what this is.

Q. The -- so you could have an individual who had heroin, oxycodone, and fentanyl in their system at the time of death and there, there's a chemical comparability to those; correct?

A. Correct.

Q. And you have testified previously, I believe, that it's difficult to, to tell which drug is which because they break down in the same ways in the body; correct?

A. What I'm -- so what I'm -- my response is this. That for the Chief Medical Office to decide -- Chief Medical Examiner's Office to decide it's oxycodone, if someone had in their system codeine, oxycodone, and tramadol, when you use three different drugs, they would be able to tell.

The reason that's important is then you can judge the patterns over the years; what drugs are causing death in 2011, what drugs are causing death in '12, '13. So if we -- if we attributed every drug in the system to all deaths, we would never be able to examine and understand better what are the trend lines in the state of deaths. So this is, this is the fundamental principle.

Q. My question was a little different. My question was I believe you've testified previously that when heroin, oxycodone are in somebody's system, they, they decompose or

they interact in the body in the same way and it's difficult to separate one from the other; correct?

A. Yes.

Q. So, so you could have somebody and these numbers could include somebody who's got heroin in their system and oxycodone in their system and fentanyl in their system and they're all opioids, but they're -- and it's very difficult to separate the three because they, they have the same rough chemical composition; correct?

A. So, Mr. Hester, for the benefit of the Court, can I just explain in a non-technical way what happens in a death?

Q. No, I need you to answer my question.

THE COURT: Just answer his specific question, please.

THE WITNESS: It's possible.

BY MR. HESTER:

Q. And when we're looking at these, at this bar chart on Figure 11, we, of course, don't know --

THE COURT: It's a little after noon, Mr. Hester, so whenever you, you're ready to get to a point where you want to stop.

MR. HESTER: I had I think two or three more questions, Your Honor, and then I can stop --

THE COURT: Go ahead.

MR. HESTER: -- and have a nice lunch. I'll just

take three or so minutes.

THE COURT: Okay.

BY MR. HESTER:

Q. When you say that it -- when we look at this bar chart, Figure 11, we don't know whether these deaths were from people who misused oxycodone. We don't know where they got the oxycodone that's listed here in this bar chart; correct?

A. We would not be able to tell that.

Q. Okay. One more question, or one more set of questions.

On Exhibit P-44227, this is the Viral Hepatitis Epidemiological Profile.

A. I have it.

Q. I want to just point you to Page 6 on this document, please.

A. Yes.

Q. I'm sorry. It's Page -- yes, on Page 6.

MR. HESTER: Your Honor, I should probably stop because I'm not as well organized on this document as I should be and I can just clean this up.

THE COURT: All right. We'll be in recess until 2:00.

And I hate to make you come back, Dr. Gupta.

THE WITNESS: It's okay, Your Honor. Thank you.

MR. HESTER: Thank you, Your Honor.

MS. KEARSE: Your Honor, I think for timing purposes, we'll have about maybe 30 minutes. I'm going to have some questions. Mr. Farrell may have a couple questions, but just so the Court's timing. But what I've got is 30 minutes of redirect and we should be done this afternoon, Your Honor.

THE COURT: Well, you're going to cross-examine, too, are you not?

MS. CALLAS: Yes, we are, Your Honor.

MS. KEARSE: I'm sorry. Nevermind.

MS. CALLAS: That's all right.

THE COURT: All right. I'll see everybody at 2:00.

(Recess taken at 12:06 p.m.)

THE COURT: You have some more questions, Mr. Hester?

MR. HESTER: Just a few, Your Honor. Just a few.

THE COURT: Okay.

BY MR. HESTER:

Q. Good afternoon, Dr. Gupta.

A. Good afternoon.

Q. I just have a few questions. We spoke this morning about NAS. Do you recall that discussion generally?

A. Yes.

Q. And I just wanted to clarify one thing. Am I -- it's

correct that a number of different kinds of drugs can cause NAS; is that right?

A. Correct.

Q. And that includes heroin and illicit Fentanyl?

A. Correct.

Q. Cocaine?

A. It may be.

Q. Barbiturates?

A. I do not have a lot of experience with data on that, but potentially.

Q. Antidepressants can also cause NAS?

A. I do not -- I'm not aware of specific data to that at this point.

Q. But definitely heroin and Fentanyl could -- could be sources of NAS?

A. Certainly could be.

Q. Let me ask you, Dr. Gupta, to turn to Exhibit 44227, the document we were on just before lunch when I was having trouble finding my way. Let me ask you to look at Page 6, please. And under the executive summary in the first paragraph, I wanted to point you to the next to the last sentence. It says, "The most common risk factors reported among cases of hepatitis B and C are drug misuse, both injection use and non-injection use." Do you see that?

A. I see that.

Q. Is that a correct statement?

A. That's -- evidence points to that, yes, sir.

Q. So, that drug misuse is the most common factor or cause of hepatitis B and C?

A. For new cases in West Virginia, yes, sir.

Q. And let me ask you to look at Page 12 of the document, please, and I wanted to point you to the bottom of the page. Do you have it there?

A. Yes, sir.

Q. The bottom of the page, there's a chart, and this is a chart headed "Risk Factors Reported in Acute Confirmed Hepatitis B Cases, 2012-16", correct?

A. Correct.

Q. And the leading risk factor is injection drug use; is that right?

A. Yes.

Q. And so, injection drug use would include use of heroin and Fentanyl?

A. Yes.

Q. And it would include misuse of prescription opioids that have been crushed and then injected; is that right?

A. It could be.

Q. And what other forms of injection drug use are there?

A. It could be -- the others probably close to it would be some version of meth.

Q. Meth injected by --

A. Methamphetamine could also -- could also be injected.

MR. HESTER: Okay, thank you. Those are all the questions I have, Dr. Gupta.

Your Honor, one housekeeping point. I did want to move into evidence Defendant's Exhibit 3616, the West Virginia Board of Medicine Quarterly Newsletter.

THE COURT: Is there any objection to that?

MR. FARRELL: No objection, Your Honor.

THE COURT: It's admitted.

DEFENSE EXHIBIT 3616 ADMITTED

MR. HESTER: Thank you.

Thank you, Your Honor.

MS. CALLAS: Good afternoon, Your Honor.

Good afternoon, Dr. Gupta. My name is Gretchen Callas. I represent AmerisourceBergen.

I may wait one moment while I have a tech person come in. His name is Richie. He should be here shortly.

THE WITNESS: Certainly.

MS. CALLAS: But I promise just to have a few questions for you.

THE WITNESS: Sure.

(Pause)

MR. FARRELL: Your Honor, while we're filling dead space, I'd like the record to reflect that Ms. Gretchen

Callas was my mentor on the Law Review at West Virginia University in 1996, now that it's placed in the permanent record.

MS. CALLAS: I have to move to strike, Your Honor, all of that.

THE COURT: Farrell always finds a way to tell me that he was on Law Review. I've got it.

(Laughter)

MS. CALLAS: At my expense, no less.

All right. Are we ready? I hope.

THE COURT: Technology, we're imprisoned by it, aren't we?

MS. CALLAS: Yes, that's true.

CROSS EXAMINATION

BY MS. CALLAS:

Q. Okay. Dr. Gupta, we've spent a good bit of time over the past two days talking about the Controlled Substances Monitoring Program and I do want to ask you a few more detailed questions about that, sir. You, in your role as the Commissioner for the Bureau of Public Health, mentioned that program in a number of reports; is that correct?

A. Yes.

Q. And you believed it was an important tool to use as we dealt with overdose death rates; is that right?

A. Yes, as well as the overall volume of prescriptions out

there.

Q. There were a number of specific key recommendations you had in some of your reports that related to the CSMP; is that right?

A. That would be accurate.

Q. And in your role as the Commissioner for the Bureau of Health, you gained some understanding of what West Virginia's system could and could not do; is that right?

A. That would be correct.

Q. And you were familiar with the fact that each year, beginning in about 2012, the Board of Pharmacy did publish an Annual Report regarding the CSMP. Were you aware of that report, sir?

A. I am aware generally that the reports are published.

Q. Okay. So, I'm going to have Defendant's Exhibit 2904.

MS. CALLAS: May I approach, Your Honor?

THE COURT: Yes.

MS. CALLAS: Thank you.

BY MS. CALLAS:

Q. So, Dr. Gupta, take a moment just to look that over. I'll represent to you this is the 2014 Annual Report of the West Virginia Board of Pharmacy related to the West Virginia Controlled Substances Monitoring Program. It would have been published around the time you took office as the Commissioner of the Bureau of Public Health; that is, it

looked back at the entire year of 2014. Is this the type of document you may have used as you studied the issues in West Virginia related to opioid use and abuse?

A. This would certainly be one of the several documents we would consider looking at.

MS. CALLAS: Okay. I would move the admission of Defendant's 2904.

THE COURT: Any objection?

MS. KEARSE: No objection.

THE COURT: It's admitted.

DEFENSE EXHIBIT 2904 ADMITTED

BY MS. CALLAS:

Q. Okay. Let's start, Dr. Gupta, by looking at the very first sentence of the Executive Summary. This report is actually required by West Virginia statute 60A-9-5(j). Do you see that?

A. Yes.

Q. Okay. If you proceed down through that paragraph, you'll see that this report will recommend legislation to enhance the CSMP in an attempt to reduce the quantity of pharmaceutical controlled substances obtained by individuals attempting to engage in fraud and deceit. Do you see that language, sir?

A. I read that.

Q. And do you understand that was one of the objectives of

the CSMP system, to reduce fraud and deceit?

A. Sitting here, I couldn't tell you exact objectives of the establishment of CSMP. I do read this and I believe this was a genuine effort on this part for this purpose.

Q. Okay. At the bottom of this first page, you'll see a description of the history of the CSMP. Do you see that, sir?

A. I see it.

Q. The West Virginia Controlled Substances Monitoring Act was implemented in 1995 to track only Schedule II controlled substances. Do you see that?

A. Yes.

Q. Okay. Further in the paragraph, it indicates that the CSMP was modified in 2002 by a legislative act that encouraged -- an initiative to encourage safer prescribing of all controlled substances in Schedules II, III and IV, to reduce their abuse and limit the diversion of those substances within the state; is that right?

A. That's correct.

Q. So, we expanded our CSMP in 2002 to include both Schedule II, III and IV substances, right?

A. That would be accurate.

Q. Okay. The next page, at the top, the last sentence of the first paragraph indicates that in December of 2004, the Board of Pharmacy implemented further changes to the CSMP to

eliminate the third party data collection and to permit both direct reporting and direct access via an internet-based program. Do you see that?

A. I see. I read that.

Q. And am I correct, sir, that when we talk about reporting, we're talking about dispensers of controlled substances, such as pharmacies? They would report to the CSMP; is that right?

A. I could speak to my knowledge from 2015 to 2018 and ongoing as a licensee for the State of West Virginia for medicine. If I was to prescribe a controlled substance, Schedule II to IV, I would have to obviously register with CSMP and then obviously utilize that to look at.

Q. Okay. But do you understand as your role as Commissioner for the Bureau of Health that pharmacists had an obligation to report what they were dispensing to the CSMP? And I can rephrase that question, if you would like.

A. As the Commissioner, I did not have oversight of either the CSMP, or Board of Pharmacy, or the pharmacies. So, a it's little difficult for me to really talk to the fact matters of other organizations. I can speak to what was a role of the Board of Pharmacy and CSMP with the Bureau of Public Health, but it's hard for me to talk about what the role of Board of Pharmacy's regulations of pharmacies was.

Q. Okay. But as a physician, you do understand that by

2004, physicians in West Virginia had direct access via an internet-based program if they wanted to check or register with the CSMP?

A. Once again, not having come to the state before 2009, I can definitely read the document and say it, but I did not have fact or knowledge of that.

Q. Okay. Let's look down the page a little further. Under the heading "West Virginia's Controlled Substance Monitoring Program Description and Reporting", it indicates that this is a central repository maintained by the West Virginia Board of Pharmacy for collected data related to the prescription and dispensing of all Schedule II, III and IV controlled substances. Is that your understanding, sir?

A. That -- that is.

Q. And you'll see there's a list, a bullet point list, right below that paragraph that begins with "name of prescribing practitioner". Do you see that list, sir?

A. I see the list.

Q. Okay. And this is information that is collected and housed in this West Virginia CSMP; is that your understanding?

A. That's my understanding.

Q. Okay. So that a prescriber who accesses the system should be able to see his or her name as the prescribing practitioner, their address, DEA number. There is available

in this database the date the prescription was filled or dispensed. There is in this database the number of refills authorized by the prescription, the source of payment, the patient's name, address and date of birth, the name, national drug control number, quantity and strength of the controlled substance dispensed. Do you see that?

A. I do see that.

Q. That's quite a bit of helpful information; would you agree?

A. That would be helpful.

Q. And all of this information had been collected in West Virginia from pharmacists and was available to physicians for a long time; would you agree?

A. I could not testify in my position as either the Commissioner or the State Health Officer as to the facts of that matter.

Q. If you'll go down one more paragraph as required by West Virginia Code 60A-9-5, you'll see there, sir, a list of those who have access to all of this information. Do you see that description?

A. I'm trying to read through it. Which paragraph? Which sentence is that?

Q. It starts with, "As required by West Virginia Code, information contained in this central repository is confidential." Do you understand that to be true?

A. Yes.
Q. Okay. And that's because it's -- it is protected healthcare information, is it not?
A. Correct.
Q. Patient's name, date of birth, their doctor and their medications; is that right?
A. Right.
Q. Okay. So, this is not public information housed in the CSMP and it indicates in this paragraph the information is open to inspections only by, and then there's a list specifically, inspectors and agents of the Board of Pharmacy, correct?
A. That's correct. And if you would like me to, I can help the Court understand really what it meant, just information I can share. I'm happy to.
Q. Yes. If you have information about who can access this CSMP, I would be interested to hear that.
A. Yes. So, these individuals, my understanding is, could access on a case-by-base basis, but what they could not do is what we call fishing. They could not go out and start looking for cases random.
Q. And that is actually something that was changed slightly in 2012, was it not, with the enactment of the Senate Bill 437?
A. We could go back and look at that, but my understanding

when I came into the office in 2015, you still could not do fishing.

Q. Okay. Well, let's look. So, we'll leave this document for a moment or two and let's go to Defendant's Exhibit 3105, which is the Senate Bill 437.

THE COURT: Would the DEA have access to that information?

MS. CALLAS: I think they are likely to be identified in that paragraph, Your Honor, as specific law enforcement members.

BY MS. CALLAS:

Q. Okay, Dr. Gupta, let's look at -- it is identified in the lower left corner as a 16 in Defendant's 3105. Actually, let's go to 18. So, toward the back of that exhibit, lower left side, you'll see 3105.00018.

A. I see it.

Q. And I'll direct you to the middle of the page.

MS. CALLAS: I don't know. Do we have this document? Okay, thank you.

BY MS. CALLAS:

Q. You'll see a 3. "The Board shall establish an Advisory Committee to develop, implement and recommend parameters to be used in identifying abnormal and unusual usage patterns of patients in this state." Do you see that language?

A. I see it.

Q. Okay. So, this is the creation in this bill of an Advisory Committee and if we go down to B toward the bottom of that same page, it also states that, "The Board of Pharmacy shall create a West Virginia Controlled Substances Monitoring Program Database Review Committee of individuals", and then they're described there. Do you see that?

A. One second. Yes, I see it.

Q. Okay. Is it your understanding, Dr. Gupta, that this was a newly created committee that could do, in some ways, what you just described as using the data in the Controlled Substances Monitoring Program?

A. So, if I can expand.

Q. Yes, please.

A. The fishing piece was still not allowed, meaning if you had Jane Doe taking prescriptions, you cannot go and follow up with Jane Doe because this was a very sensitive matter that could be of use for many other purposes. So, what you could do with this new created Advisory Committee is perhaps look at who are the top physicians who may be having more associated overdose deaths or things like that. So, there was some purpose, but it was not an end-all be-all.

Q. Would you agree, Dr. Gupta, that until this law was enacted in West Virginia in July of 2012, we could not use the data sitting in the CSMP to identify the top ten

prescribers in West Virginia?

A. That would be accurate.

Q. Okay. We could not use this data to identify patients who were seeing multiple doctors or visiting multiple pharmacies with multiple prescriptions?

A. You technically could by -- and so, if I was a physician prior to this legislation and if I went in and I saw my patient had gone to other places, then I technically could see that, but what you -- one cannot do before and cannot do after this legislation is target individuals through this fishing piece. So, that could not be done.

Q. I am going to suggest we go back and look at the 2014 Annual Report one more time because it does discuss the Committee. So, if we go to the last -- or the next page. One more page.

So, we'll see right in the middle of that page a paragraph that begins, "As created by Senate Bill 437", which we were just looking at, "the Controlled Substances Monitoring Program Advisory Committee and the Controlled Substances Monitoring Program Database Review Committee have been actively trying to address substance abuse issues in the state through use of the CSMP"; is that correct?

A. That's accurate.

Q. And you understood in your role as the Commissioner they were attempting to use the CSMP for that purpose?

A. I understood and we partnered with them.

Q. If we go down one paragraph, "The Database Review Committee evaluates those who have been identified as outliers to decide appropriate action. Individuals that have been classified as patients, prescribers or dispensers that warrant additional scrutiny are being pursued in a number of ways." So, that's what you and I were just discussing; is that right?

A. Correct.

Q. And so, this was ongoing in 2014 but, as you've testified, none of this could happen prior to 2012; is that right?

A. That would be accurate.

Q. Okay. The next sentence, "Thousands of letters have been sent to practitioners concerning patients visiting large numbers of prescribers and getting prescriptions." Do you see that?

A. Yes.

Q. So, were you aware that the Board of Pharmacy was sending out thousands of letters to West Virginia doctors about their patients?

A. We certainly had discussed that with Board of Pharmacy so, yes.

Q. And one of the reasons that the Board of Pharmacy had to send out thousands of letters to doctors was because the

doctors were not accessing the information available to them on the CSMP; is that right?

A. Can I explain that?

Q. Sure.

A. So, doctors practice culture behavior is not easy to change and we have to deploy all the tools that are -- in our ability to do that. And the thought behind this was to, once again, look at the high prescribers and then begin to nudge those prescribers and remind them of their both obligation to their patients, as well as obligation to law.

Q. Now, my understanding of these letters was also to let a doctor know when they had a patient who was seeing not only this doctor, but perhaps up to ten, or more than ten other doctors for controlled substance prescriptions; is that right?

A. I don't recall the contents of the letter but, certainly, as we found in our social autopsy, if you were seeing more practitioners, more pharmacies, you were so many more times likely to die. So, this is very consistent with that, to tell doctors that you have maybe patients -- that you have a high volume of patients. I don't exactly remember if it was also -- because that would be divulging other information to patients, so I don't exactly remember that.

Q. Let's talk a little bit about the usage by West

Virginia doctors of this system. It was an on-line system beginning in 2004. I'm going to ask you, Doctor, to look for Exhibit 3036, which was introduced earlier today. It's the West Virginia Expert Pain Management Panel Guidelines. Do you see that?

A. Yes.

Q. On Page 9 of that, those guidelines, you'll see a reference to the Controlled Substances Monitoring Programs and the description of those programs. "The Prescription Drug Monitoring Programs, PDMPs, also known as Controlled Substance Monitoring Programs, CSMPs, must be fully utilized to reach their potential in controlling prescription drug abuse and diversion." Do you agree with that statement?

A. Yes.

Q. "However, in the majority of the 49 states with operational PDMPs, participation by prescribers and dispensers is voluntary with utilization rates well below 50%." Is that right?

A. It's written there. It must be accurate.

Q. Okay. Do you know what percentage of West Virginia physicians are registered to use our Controlled Substance Monitoring Program?

A. I could not tell you right now.

Q. Before we leave this document, Dr. Gupta, I would like you to turn back to Page 4 and I would just like to ask you

somewhat randomly about Dr. Ahmet Ozturk. Do you see his name below your name on the panel member list?

A. I do see it.

Q. Do you know Dr. Ozturk?

A. I do not.

Q. Okay, but he is a -- it suggests a physician at Marshall University who was a participant on this expert panel?

A. I see his name.

Q. Okay. So, let's go back to physicians and physician usage of the CSMP. It's correct, if I am a physician and I am writing a prescription for a controlled substance, I could utilize this West Virginia database to see if my patient is receiving this same prescription from anyone else; is that right?

A. That's right and that's the best practice.

Q. Okay. Now, doctors in West Virginia needed to be encouraged to register for the CSMP; is that right?

A. Correct.

Q. In fact, they had to be forced to do so in 2016 by law?

A. There was legislation requiring that, yes.

Q. And we talked about that a little bit earlier. It's Exhibit 3015. And I am going to ask you to look at a particular page in that exhibit. It's the very last page. So, I think you were asked earlier about whether doctors

were required in West Virginia to register and we concluded after reviewing this document that they were not required to until 2016; is that right?

A. I believe so.

Q. Okay. In fact, practitioner -- "Any practitioner who fails to register with the West Virginia Controlled Substance Monitoring Program and obtain and maintain online or other electronic access", this is paragraph F., "to the program will be fined $1,000.00." Do you see that?

A. I see that.

Q. So, there was actually a penalty attached to failure to register and maintain your online access?

A. Yes. That made me register.

Q. Okay. I have one other Board of Pharmacy Annual Report, the Controlled Substances Monitoring Program 2016 Annual Report. So, we're going to jump ahead two years and we'll look at that.

MS. CALLAS: May I approach?

THE COURT: Yes.

MS. CALLAS: Thank you.

BY MS. CALLAS:

Q. So, Dr. Gupta, it's now two years after the last report we looked at. This is the 2016 Annual Report of the Controlled Substances Monitoring Program and, particularly, I'd like to direct your attention to Page 4 of this

document, which is entitled "CSMP Dispensing Statistics".

A. Yes.

Q. It does indicate in the very first sentence that, "Overall dosage unit dispensing numbers have declined over the last several years", and that would be specific to controlled substances, correct?

A. Correct.

Q. And not -- not other medications.

I'm actually on the wrong page. I apologize. I was getting onto a different topic. It's the page before. That's what I wanted to look at.

So, Page 3. Sorry about that.

This page has a chart and a bar graph and the first -- the chart actually indicates active users of the CSMP for 2014. Do you see that?

A. I see the table.

Q. Okay. And I think what I would like you to notice is if we look at the number of prescribers who are indicated to be active users of our Controlled Substances Monitoring Program in 2014, we had 2,537?

A. Yes.

Q. And, by 2016, we had almost tripled that number, not quite; certainly doubled that number to 6,618; is that right?

A. Yes.

Q. So, we had 4,000 more physicians or prescribers using the CSMP over a two-year period?

A. Correct.

Q. Okay. At the bottom of the page we have the number of user queries, so those are usage basically of the system; would you agree?

A. Yes.

Q. And we can see over time going back to 2008 how many more queries we have by prescribers of our system.

A. Yes.

Q. Okay. And you would agree this is all a positive improvement?

A. Certainly.

Q. Okay. But the fact of the matter is that even in 2008 when we had, oh, what, 300,000 queries, as opposed to nearly a million, in 2008, this system was still in place and was available for physicians to be using; is that right?

A. As I testified prior, it was available in a voluntary capacity.

Q. Now, there's no reason to believe there's anybody but physicians that could access this in a regular user capacity; is that right?

A. Can I expand on that, please?

Q. Of course.

A. So, there is some ability for Advanced Practice

Registered Nurses to prescribe, as well. So -- and for even physicians, it's usually the staff that does it. And so, in the answer can anybody else, it's usually the staff was doing the query, but there's nothing beyond their office or any prescriber for that who is licensed to prescribe.

Q. Okay. Thank you, Dr. Gupta.

Okay. Let's switch gears and then we'll wrap up. The Board of Medicine, you've testified that you served as the Secretary of the Board of Medicine for approximately four years; does that sound right?

A. Yes, Ms. Callas.

Q. And the Board of Medicine for those doctors that are MDs in the State of West Virginia is both a regulatory body, the licensing body, and they also conduct investigations; is that your understanding?

A. Yes. And educational body, as well, I think we can agree on.

Q. Okay. The Board of Medicine decides and can investigate whether a physician has engaged in the improper practices of medicine; is that right?

A. If they are violating the -- what we have called the West Virginia Medical Practice Act, then there could be complaint lodged. There's a formal procedure and a Board does not itself make that decision and go and pick doctors. There has to be a formal complaint launched according to

clearly the statute. And then, that complaint could be investigated through the Board of Medicine's investigators. And there is a Complaint Committee to which the complaint goes through. So, it is an entire process that has -- that has elements to it.

Q. Okay. Well, let's break that down a little bit. That was helpful. So, if -- if there is no complaint, the Board of Medicine does not just initiate an investigation of a doctor on its own; is that right?

A. That's correct.

Q. And if the Board of Medicine were to receive information from, let's say, this CSMP Review Committee, then here are your top five prescribers, that is not a basis to initiate an investigation, is it?

A. That's correct.

Q. Okay. So, we need a complaint about a prescriber to initiate an investigation of that doctor's prescribing practices?

A. A formal complaint has to be filed in accordance with the law regulating the Board of Medicine.

Q. And, as the Secretary of the Board of Medicine, you were at times involved in that investigation process to the extent there might be a consent order that was issued?

A. So, I can talk about my role. I was not a member of the Complaint Committee, but I was the Secretary of Board.

I definitely -- the orders, consent orders, were signed by myself, the Board President, and there were rare occasions in which the President, the Vice President would be conflicted in making that decision in which I would chair the Committee to make the decision on that particular physician specifically.

THE COURT: Where did the complaints come from typically?

THE WITNESS: Your Honor, they could come from individuals like patients. They can come from a pharmacy. They could come from -- the State Health Commissioner can file a complaint if a physician -- so, and all of those things have happened, but anybody, any member of the public, can file a complaint.

BY MS. CALLAS:

Q. Now --

THE COURT: Okay. So, if I knew there was a pharmacy downtown and I -- that was writing these prescriptions and basically running a pain clinic, I could file a complaint and it would be investigated?

THE WITNESS: Yes, Your Honor. If anyone would file -- it's an on-line system, as well, anonymous. It's held anonymous by law and anyone can file a complaint if they know anything about any wrongdoings of any physician licensed under the Board and they would initiate the

complaint and investigate it.

BY MS. CALLAS:

Q. Now, those complaints are confidential; is that right?

A. Anonymous and confidential.

Q. Okay. So, I cannot, as a member of the public, do a search for a doctor to see if he is subject to a complaint?

A. So, I've just explained that. So, a complaint is filed. The first thing that happens, anonymously, the complaint goes to the Complaint Committee. Oftentimes, it can be adjudicated without further investigation, depending on the merits of the case.

Other cases, it is investigated. Should a cause be found to take it to the Discipline Committee and make a discipline, only when the found discipline is voted upon by the Board does it go public and goes in the permanent record of the physician and is public, publically available.

Q. So, the complaint and the investigation process; that is prior to a decision, is all confidential or shielded from public view; is that right?

A. Until the final decision is made. At that point, all of that becomes public, a matter of public.

Q. I'm going to ask to use an example. There is a doctor by the name of Deleno Webb. Does that name ring a bell to you?

A. It does not.

Q. Okay. I have a document that might refresh your recollection. Your signature is on it.

MS. CALLAS: So, I would ask to approach the witness with that document.

Would you like to see this, Your Honor? I don't -- it's not an exhibit. It's just to refresh his recollection.

THE COURT: Do you remember now, Dr. Gupta?

THE WITNESS: Your Honor, West Virginia is only one of a very rare few states in the country where the President of the Board and the Secretary have to physically, by ink, sign every license in the State of West Virginia. So, I signed way more of these type things than I can remember. I do, I'm trying to recollect.

THE COURT: Do you remember at all?

THE WITNESS: I remember -- I remember the case. I'd have to go through the whole thing to remember it, but I do remember the case.

THE COURT: Well, when you've refreshed him. You need to take the document.

MS. CALLAS: I -- you're right. You're right.

Let me take that back.

I wasn't sure if you were going to let me get away with that.

BY MS. CALLAS:

Q. Okay. Dr. Gupta, do you recall that the West Virginia

Board of Medicine received a complaint about Dr. Deleno Webb in or about the June of 2014 time frame?

A. I do not recall.

Q. Okay. Do you recall that Dr. Deleno Webb had a complaint at some point in time related to the prescribing of controlled substances?

A. Consequent to what I just viewed, I -- I -- there seems to be -- obviously there, but I do not recall that.

Q. Do you recall that there was an investigation that the Board of Medicine did engage in over a period of time related to this doctor?

A. I do not recall beyond what I just saw.

Q. Okay. Do you recall that there was some action taken by the Board after that investigation?

A. Once again, beyond what I just reviewed, I do not recall.

Q. So, it sounds like you don't really recall the specifics of this doctor's case, or do you?

A. I do not.

Q. Okay. Okay. Well, I appreciate you making the attempt, nonetheless. I think we have established though, assuming there was an investigation of this particular doctor, or any other doctor related to allegations of improper prescribing, the complaint and the investigation would be kept confidential and there would be no notice

provided to pharmacists, pharmacies or patients that this was an ongoing investigation; is that right?

A. I think that's correct. An ongoing investigation of the Board of Medicine in West Virginia is not subject to publicity, and media reports, and reports to other people.

Q. And while this doctor, or any other doctor is subject to an investigation for improper prescribing, they can continue to prescribe; is that right?

A. I can explain.

Q. Okay.

A. So, there are remedies in the law that they -- that's a decision of the Board. There are remedies that include seeking an immediate injunction that can make us if that's where the determination is. And in other circumstances, the -- if it's not an immediate recognized threat to the public, then they can continue to do their work until such a time a finding is found.

MS. CALLAS: Thank you, Dr. Gupta. That's all the questions I have.

THE COURT: Is there any redirect, Ms. Kearse?

MS. KEARSE: Briefly, Your Honor. I think Mr. Farrell may have a couple after me.

REDIRECT EXAMINATION

BY MS. KEARSE:

Q. Good afternoon, Mr. Gupta. I just have a couple of

things I want to follow up on. You were shown again the West Virginia Drug Overdose Deaths and Historical Overview, 41213, and I just want to go to Page 5.

MS. KEARSE: Is this working, Gina? I can use the ELMO.

BY MS. KEARSE:

Q. And you were shown on the top of Page 5 --

MS. KEARSE: Go to Figure 3 first.

BY MS. KEARSE:

Q. Do you recall that?

A. I do.

Q. Okay. And you were being asked about other drugs.

MS. KEARSE: I want to go down to the bottom of that paragraph, Gina.

BY MS. KEARSE:

Q. The number -- if you can read this on that same page that you were being asked about drug overdoses and the drugs used?

A. The last sentence -- last sentence of the first paragraph here, it says, "The number one cause of drug overdose deaths was associated opiates, making West Virginia number one in the nation."

Q. And that was in relation to the report that you did; is that right?

A. That was a -- that was part of the report.

Q. And I want to go quickly to the 2016 document, Exhibit 03036. This was the West Virginia Expert Pain Management Panel. You just actually reviewed it.

MS. KEARSE: And, Gina, if we could put the cover page on that.

BY MS. KEARSE:

Q. So you know which one, do you have that in front of you? Okay. And this is the one that had you listed there. I want to go to the first page on that document, Page 3, actually. In the middle of Paragraph 2, can you read that to the Court, Dr. Gupta? "Approximately", do you see that section?

A. I see it now. "Approximately 2 million Americans live with prescription opioid abuse or dependence. That's per SAMHSA, 2013.

Q. And the next sentence?

A. "About 75 percent of opioid addiction patients" -- I'm sorry. "About 75 percent of opioid addiction disease patients switch to heroin as a cheaper opioid source." That's SAMHSA, 2013.

Q. And that was part of the Executive Summary of that Panel Report?

A. Yes.

MS. KEARSE: Thank you, Doctor. No more questions. I was quick today. Mr. Farrell may have a

couple.

MR. FARRELL: With permission?

THE COURT: Yes. Go ahead. I assume there's no objection to the double teaming here?

MR. FARRELL: I would like to refer to it as double dipping, Your Honor. They get to triple dip, we only get to double dip.

THE COURT: Okay.

MR. FARRELL: I promise I'll make it entertaining, if not brief.

REDIRECT EXAMINATION

BY MR. FARRELL:

Q. The first thing I'd like to do is with reference to the demonstrative on Dr. Deleno Webb, despite the fact that you don't recall this particular one, your name is on this document, is it not?

A. It is.

Q. And it's in your official capacity as the Secretary to the West Virginia Board of Medicine?

A. It is.

Q. And when you reviewed this document, what is the action taking place? I'm sorry. I think the copy was taken away from him.

THE COURT: Well, she used it to refresh his recollection and that's the right way to do it.

MS. CALLAS: Yes, and I'll object to the extent you're using something that's not really an exhibit. It was used to refresh his recollection. It did not work.

BY MR. FARRELL:

Q. The document that was attempted to be used to refresh your recollection, I would like to show you as a potential exhibit to identify it.

MR. FARRELL: May I approach, Your Honor?

MS. CALLAS: Well, let me object because it's not an exhibit. It is not identified by either party in this case as an exhibit for its use at trial.

THE COURT: Mr. Hester, did you want to say something?

MR. HESTER: I'm with Ms. Callas. I agree, Your Honor, it wasn't -- it didn't refresh the witness's recollection.

THE COURT: Yes. I'm not going to let you do this, Mr. Farrell. Where are you going with this?

MR. FARRELL: Well, this is a consent decree surrendering a medical license from a doctor who was prescribing in Huntington, Cabell County, West Virginia at pharmacies that the distributor supplied. So, I'd like to begin creating a record with a surrendered license that you'll see his name throughout their documents in Weeks 3 and 4.

THE COURT: Well, I'm not going to let you do it now. You can do it later if you can get it in.

MR. FARRELL: The only problem, Judge, is that I don't know if there's anybody else whose signature is on here that I can get other than Dr. Gupta.

THE COURT: Well --

MR. FARRELL: If he can authenticate it, then it's a simple --

THE COURT: And the purpose of it is to show that this was a doctor who was prescribing opioids in Cabell County, or Huntington, or wherever?

MR. FARRELL: Yes, Your Honor, to such extent that he lost his -- he surrendered his license to Dr. Gupta.

THE COURT: Okay. And what does it show? What's --

MR. FARRELL: What we intend to show --

THE COURT: I mean what is the ultimate purpose of this?

MR. FARRELL: The ultimate purpose of this is that the volume of pills that were coming into Cabell County were responsible to, in part, the bad doctors that McKesson spent most of this morning discussing. I've got one here.

THE COURT: Well, I'm going to let you do it. I'll allow it. Go ahead.

MR. FARRELL: May I approach?

THE COURT: The objection is overruled.

MS. CALLAS: Your Honor --

THE COURT: Do you want to put anything on the record, Ms. Callas?

MS. CALLAS: Well, my only comment, Your Honor, is that if I had been permitted and, of course, I did not seek to introduce the document because it was not on an exhibit list of either party, or any of the parties, I would have asked more questions about it. So, perhaps if Mr. Farrell is going to go into much detail, if I have any additional questions, one or two at the end, I would request the right to recross.

THE COURT: Well, go ahead. He can authenticate it, if he can, and I'll conditionally admit it and then make up my mind whether I'm going to really consider it or not.

MR. FARRELL: Okay. And to be fair, I will yield the floor to Ms. Callas, if she would like to --

THE COURT: Just do it.

BY MR. FARRELL:

Q. Dr. Gupta, what is this document?

A. This is a consent order by the West Virginia Board of Medicine.

Q. And is your signature on the document?

A. Yes.

Q. In what capacity?

A. In the capacity of the Secretary of the Board of Medicine.

Q. And what does your signature indicate by affixing it to this document?

A. It indicates an official order in my capacity representing the West Virginia Board of Medicine.

Q. So, is this a formal action taken by the West Virginia Board of Medicine?

A. Yes.

Q. And is this your signature endorsing or validating this action?

A. Yes.

Q. And is this a document that is created in the usual course of the licensing of physicians in the State of West Virginia through the West Virginia Board of Medicine?

A. Created in the course of disciplining of licensing in the State of West Virginia through the West Virginia Board of Medicine.

MR. FARRELL: Judge, at this time, I would have the document marked as an exhibit and entered into the record.

THE COURT: Do you have an exhibit number for it?

MR. FARRELL: I did. Can we -- can I make one up?

MR. HESTER: Your Honor, simply to preserve the record, we do note our objection to this. It wasn't on

either parties' exhibit list.

MR. FARRELL: We'll mark it at P-9999.

THE COURT: Okay.

MR. FARRELL: Thank you.

THE COURT: My deputy gets very upset with me if I don't make you put numbers on the exhibits.

MR. FARRELL: Yes, Your Honor.

THE COURT: She's got to keep track of all this.

MR. FARRELL: Yes, Your Honor.

BY MR. FARRELL:

Q. Dr. Gupta, I think I have five categories of follow-up from cross. The first is document P-44211, which was the social autopsy.

A. I have it.

Q. And the questions that you were asked related to a correlation between prescription opioids and illicit opioids resulting in death. So, let me ask you initially this. Through your research and in your role with the -- as the State's health officer, have you been able to identify a direct correlation -- let me get the words right. Have you been able to identify a direct correlation between diverted prescription pills and the transition to using street drugs, such as heroin, Fentanyl or methamphetamine?

MS. MAINIGI: Objection, Your Honor. This is the same discussion we had yesterday. Mr. Farrell is now just

trying to gateway -- back-door the gateway discussion.

THE COURT: Sustained.

MR. FARRELL: Judge, if I can beg your indulgence for a moment, the reason I'm not trying to go in through the back door, I'm trying to go in through the front door, this was literally disclosed by the plaintiffs.

THE COURT: Well, you're trying to get an opinion from him about the gateway point, aren't you?

MR. FARRELL: Yes, because we disclosed it. Yes, that's exactly what I'm attempting to do since we disclosed it. This isn't a sandbag or a last minute attack. This literally was disclosed by us last year, October.

THE COURT: Ms. Mainigi, go ahead, please.

MS. MAINIGI: Yes. Your Honor, I'd rely primarily on the argument I made to Your Honor yesterday, which is that this is covered under -- Your Honor said he was going to reserve ruling on this and I think, yesterday, we had argument on it back and forth, including from Mr. Farrell. This falls under *Downey v. Bob's Discount Furniture*.

COURT REPORTER: I'm sorry. Can you speak into the mic? Is it on?

MS. MAINIGI: Oh, you know what? I'm so sorry. It was not on. I apologize.

COURT REPORTER: It's okay.

MS. MAINIGI: This falls, Your Honor, into *Downey*

v. Bob's Discount Furniture Holdings, which is a case Your Honor cited. Dr. Gupta was never -- Ms. Kearse with Dr. Gupta was never able to lay a foundation for the gateway. Dr. Gupta, in his capacity, would not be in a position to have -- to be a percipient witness, personal knowledge and observations, as opposed to facts supplied by others, which is what he is operating under.

He was allowed to testify as to hybrid opinions if his -- his hybrid opinions are limited to his involvement in the events giving rise to this litigation. Dr. Gupta does not have that information. He relied on studies, as he testified at his deposition for the gateway theory.

MR. HESTER: Your Honor -- I'm sorry, Your Honor.

THE COURT: All right. That's all right. You go ahead.

MR. HESTER: Sorry, Your Honor. I didn't mean to interrupt.

THE COURT: That's all right.

MR. HESTER: I was going to add, as well, I believe this is beyond the scope of our cross.

MS. MAINIGI: That is -- that's correct.

THE COURT: Well, I think that's right. I'm going to let you mark it, and we'll put it in the record, and you can ask -- you've already had him identify it, but I'm not going to let you go down the path of questioning him about

the gateway theory because -- for the reasons counsel have so articulately placed on the record. So, that's where you are, Mr. Farrell.

MR. FARRELL: I understand, Judge, and I also understand that you don't care for people arguing with your rulings. And so, the plaintiffs believe we've made appropriate disclosures and disagree with the positions taken by the defendants and I'll move on.

THE COURT: Well, you can argue with me to the extent of placing your objections on the record and the reasons for them, period.

MR. FARRELL: Yes.

THE COURT: And you've done that and I thank you.

MR. FARRELL: Thank you, Judge.

THE COURT: Okay.

BY MR. FARRELL:

Q. Dr. Gupta, you just spent some time talking about the CSMP as a tool that you use in your role in public health. In general, aside from the CSMP, where else would a person in public health be able to find data regarding physician prescribing patterns?

A. There are several other sources that folks in my position --

Q. So, let's start with direct sources. Where is the most district source to get information on where doctors'

prescriptions are being filled?

A. The -- if you're asking the sources available to me as Commissioner, State Health Officer, those direct sources could be -- there are CDC sources that provide us that, but there's also -- we used to use Quintiles IMS data. That is something that I think one of the counsel today, this morning, showed a graph at 20.8 prescriptions. That's where that comes from.

Q. That's a good point. I think that's Exhibit -- DEF-WV-747. Can we pull it up, please? So, one of the exhibits that you were asked about was the number of prescriptions per person and I wanted to follow up with that, as well.

MR. FARRELL: I think it is Page 38. There it is. No. Can you go to Page 38 first? The next page. Yeah. Back up one. There we go.

BY MR. FARRELL:

Q. So, can you in more detail describe what does this factor mean, "RX per capita"? Can you explain for the Court what that means?

A. This means the total number of prescriptions for all prescription-level medications in -- by state per person, man, woman, baby, child, by State for the year of 2016.

Q. And is this the type of data that you would rely upon in the field of public health when exercising your duties?

A. Yes. Clearly, I would be presenting on it, so yes.

Q. And not just in public health, but does the CDC rely upon this data when attempting to reach positions on physician prescribing trends or patterns.

MS. MAINIGI: Objection, foundation, Your Honor. This witness is not in a position to know what the CDC is relying on.

THE COURT: Sustained.

BY MR. FARRELL:

Q. You mentioned earlier --

MR. FARRELL: Okay, that's fair.

I would like to have blown up the bottom right-hand corner.

BY MR. FARRELL:

Q. In this exhibit that you published that the defendants entered into evidence, did you rely upon Quintiles Xponent 2017 data when creating this document?

A. Yes.

Q. Go to the next slide, please. Again, this is another data point from the document entered into evidence by the defendants. Is this data point, does it rely upon Quintiles IMS Xponent data?

MS. MAINIGI: Objection, outside the scope of the direct -- of the cross examination.

THE COURT: Well, I'm going to sustain the

objection. This is getting pretty far --

MR. FARRELL: Well, then I'll get right to the point.

THE COURT: Good.

BY MR. FARRELL:

Q. Is Quintiles IMS Xponent, is that now known as IQVIA?

A. Yes.

Q. And is IQVIA data part of the data that you rely upon in the field of public health when identifying prescriber trends of prescriptions, including opioids?

MS. MAINIGI: Objection, Your Honor, outside of the scope of the cross examination.

THE COURT: Sustained.

BY MR. FARRELL:

Q. The data that's down here that says Quintiles IMS Xponent, is this the type of data that you relied upon, and specifically relied upon, when creating this --

THE COURT: That's the same question. Mr. Farrell.

MR. FARRELL: Judge, I'm struggling to understand how the defendants --

THE COURT: Well, I'm -- I'm sorry. I didn't mean to interrupt you. Go ahead.

MR. FARRELL: I'm struggling to understand how the defendants can spend the better part of today challenging

the data sources of this witness and then, when I point out what the data sources are, their objections get sustained. I apologize.

THE COURT: Well, I've made a ruling. Go ahead. This is plowing ground that we've been over and over, I believe.

MR. FARRELL: Well, now -- and I believe you offered me the opportunity to lay the foundation through other means.

THE COURT: Well, I did, but I -- I'm not sure this is the proper way to do it at this point in the trial.

BY MR. FARRELL:

Q. Now, there are a number of questions that were asked of you during direct regarding why opioids are at a higher prescription rate in West Virginia than other states. In your role as a public health officer, have you seen any indication that obesity, say, is a driving factor in higher opioid rates?

A. Can I explain that further?

Q. Sure.

A. Shortly. So, I had mentioned this morning it's not just obesity. It's the consequences of obesity. It's what happens because of that. It's how much disability you have from obesity. It's how much arthritis you get from obesity.

So, if you start to look at the data from arthritis,

for example, from, you know, 2003 to 2017, you will see there's two points increase in arthritis.

If you similarly look -- start to look at the data of mortality from obesity, thinking if you're about to die, you're going to have need for pain because of neuropathy and other complications of diabetes.

You see that a mortality rate from obesity, Your Honor, went down over the years. They didn't go up. Similarly, the chronic conditions, the other things you will see, a disability or any level of impairment from obesity, if you'll look at that over the -- from 2000 to 2010, those levels went down, didn't go up.

Another factor is cancer that can happen from obesity. If you look at the West Virginia cancer rates, we went -- and not just cancer rates because, if you get a little spot on the skin cancer, you don't need opioids for that. It's the cancers that kill you because, end of life, that's what you use opioids for. Those numbers went down 18 percent, cancer morality, between 2000 and 2010, I believe. So, the numbers actually were trending in the opposite direction.

Q. What about age? Is the fact that West Virginia has an older population a justification for a higher rate of a prescribing of opioids?

MS. MAINIGI: Objection, foundation. He's not here as a prescribing doctor, Your Honor.

THE COURT: Sustained.

BY MR. FARRELL:

Q. Are you familiar with -- in the field of public health whether or not age is a factor in the prescribing of opioids?

A. Yes.

Q. Please explain.

A. As I testified earlier, the older one goes, there is more likely of having conditions that lead you to have chronic pain, things like arthritis, things like cancer. So, there are conditions which cause you to have an appropriate management of pain.

They could be no medication. They could be non-pharmaceutical intervention for pain. It could be pharmaceutical intervention for pain. A non-opioid. And there could be opioid interventions for chronic pain, as well. Given all of these options but, clearly, when you're older, the needs for pain management is a lot more than you are younger.

Q. Thank you. Final question. In the Exhibit P-41213 there was a discussion about the scope of your historical analysis and the testimony was that you had used the reference point of 2001 and you were asked on cross examination, or it was elicited earlier, that you looked back to 1999 and your testimony was that, in '99, West

Virginia was below the national average.

My question is, can you quantify from 1999, based on your recollection, where West Virginia fell within the national average?

MS. MAINIGI: Objection, Your Honor, foundation.

THE COURT: I'm going to let him answer that one. Overruled.

Answer it if you can.

THE WITNESS: Yes, sir. In 1999, according to the data of the Health Sciences Center, Health Statistics Center in West Virginia, our rate for overdose death rate was 4.1 per hundred thousand people. The national rate at the time was six per 100,000 people. So, our rate in West Virginia, overdose death rate, was lower significantly than the national rate and that flipped in 2001. And, by 2017-2018, it was all the way up to 57 -- 52 to 57 deaths, depending on which area you're looking at.

THE COURT: Hasn't he already testified to all this?

MR. FARRELL: Sir, he did not quantify the 1999 numbers.

THE COURT: All right.

MR. FARRELL: And I believe he did quantify the current ones. He just didn't quantify 1999.

That's all the questions I have, Judge. Thank you.

MS. MAINIGI: No recross, Your Honor.

THE COURT: Mr. Hester, do you have anything?

MR. HESTER: I have one question, Your Honor, and I will be very brief.

RECROSS EXAMINATION

BY MR. HESTER:

Q. Dr. Gupta, just one question for you. Ms. Kearse asked you to look at Plaintiff's Exhibit 41213. This is the Historical Overview of Drug Overdose Deaths, 2001 to '15. And Ms. Kearse pointed you to Page 5 and asked you to read into the record the sentence that the number one cause of drug overdose deaths was associated with opiates. Do you recall that?

A. Yes.

Q. And the reference opiates there includes illegal drugs, illegal heroin, illicit Fentanyl. It's not prescription opioids; it's all opiates, correct?

A. Opiates, particularly, are naturally synthesized. That would include several of the nonsynthetic, natural so-called, opioids. That would include illicit, as well.

Q. So, include heroin?

A. Yes.

Q. And would include Fentanyl that's laced into heroin, correct?

A. To the point that -- Fentanyl, I'm not -- I have not

known Fentanyl to be a naturally occurring opioid, so I would include Fentanyl in that.

MR. HESTER: Okay, thank you. That's all the questions I have.

Thank you, Your Honor.

THE COURT: Ms. Callas, do you have anything?

MS. CALLAS: No, Your Honor. Thank you.

THE COURT: May Dr. Gupta be excused?

MS. MAINIGI: Yes, Your Honor.

THE COURT: Thank you, sir, very much, and we appreciate your indulgence with us. And I know you've got things you need to deal with and I wish you the best. And thank you, sir, very much for being here. Appreciate it.

THE WITNESS: Thank you, Your Honor.

THE COURT: You're free to go.

THE WITNESS: Thank you.

MR. FARRELL: Judge, may we have five minutes to make a witness change?

THE COURT: Yes. Let's be in recess for five minutes.

(Recess taken)

MS. CALLAS: Your Honor, I have one housekeeping matter. If I might move the admission of Defendant's Exhibit 2906. It was the 2016 Annual Report.

MS. KEARSE: No objection.

THE COURT: Thank you. Is there any objection to that?

MS. KEARSE: No objection, Your Honor.

THE COURT: All right. It's admitted.

MR. MAHADY: Your Honor, Joe Mahady from AmerisourceBergen.

There's one other issue we'd like to raise at this time if that's okay with you.

This issue relates to Dr. McCann who will be appearing on behalf of the plaintiffs on Monday. You recall Dr. McCann is their ARCOS expert. And the plaintiffs intend to use Dr. McCann to present his analysis of the ARCOS data.

A few weeks back, the parties reached a stipulation that required the plaintiffs to disclose two weeks prior to Mr. McCann's testimony the charts and summaries and graphs that they intend to use with Dr. McCann. That deadline was last Monday.

Last Monday we received 7,000-plus pages of charts and summaries from the plaintiffs for Dr. McCann.

The large majority of these charts were from Dr. McCann's expert report in Track Two. It has a massive appendices. And it was the very reason we entered into the stipulation, so we could have some understanding of what they actually intended to use with Dr. McCann.

We have worked with the other side, and Mr. Mougey

specifically. And while we have made some progress, we are pretty far apart.

A few days after the disclosure of 7,000-plus charts, we got a more limited disclosure of 4,200 charts.

Where we are at right now a few days before he is called at trial is roughly 3,500 pages of charts and summaries and graphs.

And what we are looking for from the Court is some guidance here and for the plaintiffs to provide real disclosures about what they actually intend to use with Dr. McCann on Monday.

THE COURT: Yeah. I think it's reasonable to provide specifically what you're going to use. That's the purpose of working these things out.

MR. MOUGEY: May I respond, Your Honor? Peter Mougey for the plaintiffs. If I could have the ELMO, it would be great.

And I agree with Mr. Mahady that some guidance would be good, but let me, if you don't mind, Judge, give you a little more detail than opposing counsel just provided.

I've put these into buckets or categories and I apologize for my rudimentary chart here.

I'm going to start off with what we have summarized, which is 500 million lines of data. And, Your Honor, if I were to print that out, that would be 25,000 banker boxes.

Now, I assume if I showed up with anywhere near that amount of banker boxes, I would be in trouble.

So I've broken them down here for you and I'm going to give you the conclusion. And the conclusion that Mr. Mahady is objecting to is approximately two banker's boxes. And let me break those down even further, Your Honor.

The data summaries that I provided Mr. Mahady two weeks ago were 150, 200 pages approximately. Each one of those pages has a footnote at the bottom that references the source material from the backup. That's the 4,000 pages. So the 4,000 pages are the support.

As you know, Mr. Fuller, Mr. Farrell, Mr. Majestro have tried a few times to get -- reach some conclusion with the defendants about what to do and how to get this data in.

So I have the 4,000 page back-up to the 150, 200 pages of -- which is the primary source of what we want to use. In the event that the defendants object, call for a specific number, this is the reference in the back-up for the data summaries.

I believe where most of the volume is coming from, Judge, is on the pharmacy summaries, in the pharmacy packets. The pharmacy packets are approximately 3,000 pages.

Now, about 700 of those pages are charts and summaries pertaining to -- and I'm not going to go into any color, but

I'm going to give you an example, Judge.

So the example I'm going to give you is just simply hydrocodone and oxycodone.

I have this chart, as you see here, in dosage unit and in MME and in base weight. Some of the -- we'll call them just generally algorithms or tests from the defendants rely on differences; dosage units, base weight, and MME.

So what I've done, Judge, is I've provided these charts three different ways. So when Your Honor is asked to make a decision several months down the road, we have them each way.

Now, further adding to the detail is if for a specific chart or -- I'm sorry -- a test or an algorithm, let's just use, for example, that the chart -- that the test or the algorithm is 10,000 just to make it random. And you can't tell from that bar chart what the exact number is.

So in order to anticipate a potential objection that you can't tell the specific number and it exceeded that threshold, I've provided the detailed back-up so you can see the exact numbers.

So most of this volume in the two banker's boxes that we've distilled down from 27,000, most of that volume is in these pharmacy packets that we've provided charts with dosage units, base weight, MME, and then the specific back-up for Your Honor.

THE COURT: Well, what are you actually going to use when he testifies?

MR. MOUGEY: That was my next point. Thank you.

So, Your Honor, what I would like to do, and that's why I'm glad we're having this conversation today, is I would prefer -- these pharmacy packets are set up in the exact same way, same table of contents, same chart up front. And every single chart will obviously have different numbers, but it's the same chart every time.

So what I was hoping to do, Your Honor, is to go through a handful of these, four, five, six, a couple per defendant in detail demonstrating to Your Honor what's there.

The -- Dr. McCann will testify that the remaining pharmacy packets are duplicative in the way they're organized, the way the charts are formatted. They have DU, MME, and that they're repetitive. And I'd like to use exemplars of the five or six and then introduce the entirety of the pharmacy package, packets with -- there's about 3,000 pages.

But at the end, Your Honor, I've got -- which I gave to Mr. Mahady the specific slide deck that we're going to use, that we're going to introduce into evidence, the 1006s, the couple hundred pages. And most of this falls into the pharmacy packets.

But, Judge, I've got 500 million lines of data down into two boxes. I feel like we've done a -- we've worked really hard to get it down to a manageable amount that the Court can, can, can process and the defendants can process.

And -- but for varying reasons, what I am a little worried about is sitting down after we put in Dr. McCann and then two weeks from now, you're going to have a specific question about a test or a threshold as we go further and further down. And I want you to have the tools to be able to make a decision. And by doing that, I've given you a few different options of whether it's a chart or whether it's a table.

But for the most part, Judge, I think we've got everything dialed in pretty tight.

MR. MAHADY: Your Honor, if I may respond.

Mr. Mougey does not disagree with me that their disclosure currently rests at over 3,000 pages of charts. And I don't disagree with Mr. Mougey's characterization that a lot of it is I believe he said duplicative and repetitive. We think a lot of it is unnecessary.

But what Mr. Mougey is trying to say is we are going to give you a couple examples of some pharmacy charts. And then we're going to ask you to take into the record 3,000 pages of charts that the witness did not go through in court.

There is a separate fundamental issue we have as to whether or not these charts and summaries even fall under Rule 1006 and we can deal with that at a separate time.

But for today's purposes, we're four days out from this witness testifying. We have a universe of 3,200 charts and we're being left to guess as to what's actually being --

THE COURT: Well, I think you ought to tell him specifically what you plan to offer through Dr. McCann and, and if -- and leave it at that. And so they can have a legitimate opportunity to prepare.

And if we have to get into any -- if a situation develops that we have to get into any of this other documentation, then I'll deal with that at that time.

But I think the defendants are entitled to notice of what you're actually going to use and so that it will be in a form that is manageable.

MR. MOUGEY: I agree with you, Judge, and I think we have. We've given them the pharmacy packets. We've given them a couple hundred pages of decs.

THE COURT: Well, I'm not going to expect them to be prepared to respond to 3,000 pages of documentation produced just a few days before the testimony.

MR. MOUGEY: I'm glad you asked that because I can point that out. Let me further clarify when this was -- let me go back to this bucket chart for a second.

The only one of these categories, Judge, that was produced at the 1006 deadlines is that, the 150 to 200 pages.

These pharmacy packets, the pharmacy summaries -- I'm glad you brought this up. The pharmacy packets were produced in two pieces. One is Cabell County Bates number 1 which were -- some of the documents were included back in 2019.

But the entirety of the pharmacy summaries were provided to the defendants in Dr. McCann's expert report in August of 2020.

So this -- the only thing that was produced within the two weeks is that 150, 200 pages. Every single piece of paper in this pharmacy and every one of the back-ups, depending on what their objections are, were produced as attachments to Dr. McCann's report.

THE COURT: Well, it seems to me they're entitled to know what you're specifically going to offer through Dr. McCann so they can prepare to confront that. And that's what I expect you to do. And I, I don't think we need to be cluttered with all this other paper. I mean, you can introduce the summary and then -- well, I'm not going to go beyond that.

Does that satisfy you, Mr. Mahady?

MR. MAHADY: Your Honor, I appreciate what you're

saying and I agree with you. Hearing Mr. Mougey speak right now, I think we're still passing each other because what he is saying is that they have satisfied the direction you're giving.

We're at 3,200 pages of charts. That's not satisfactory. And he keeps talking about these pharmacy packets and saying, "We've told the defendants exactly what we're going to do."

What Mr. Mougey said was, "Here take a look at this packet." It's 80-plus pages. He also pointed to another packet that's 300-plus pages. That's not what they're going to show Dr. McCann on Monday.

THE COURT: I want you to let them know what you're going to show Dr. McCann on Monday and provide that. And --

MR. MOUGEY: May I ask for some direction, Your Honor, because I think this is where the issue is?

I would be more than happy and -- to limit myself to these charts. What my concern is, and what I said earlier, Your Honor, when you narrow down the charts, it gets down to a few hundred pages, which is what I've identified to Mr. Mahady.

Bear with me, Judge, one second.

If, if I leave it at these charts without the back-up data and say my partner, Mr. Rafferty, goes to put it in the

McKesson case and they're talking about specific thresholds on specific numbers for a test and they increase those thresholds and Your Honor asks Mr. Rafferty how many pills specifically --

THE COURT: Well, we'll deal with it when it comes up.

MR. MOUGEY: But what my concern is if Dr. McCann's off the stand, and based on your direction to us so far -- and I apologize but I do appreciate your guidance. If Mr. Rafferty needs a specific number on the threshold that's in this packet --

THE COURT: You're arguing with me now and I think I've made it as clear as I can where I stand on this. And both of you are going to have to make the best of it.

MR. MAHADY: Thank you, Your Honor.

MR. MOUGEY: Thank you, Your Honor.

MR. SCHMIDT: Your Honor, may I raise one hopefully much smaller issue? Paul Schmidt from McKesson.

THE COURT: Okay.

MR. SCHMIDT: It's 15 documents. Yesterday we got a new reliance list for Mr. Rafalski who the Court may recall is the plaintiffs' DEA expert.

When we got these new reliance documents, we said, "Can we have an update deposition? It would be short." We were told, "No."

By chance, Mr. Rafalski was set to be deposed in another Georgia opioid case on Saturday and that deposition got pulled down because they told us he was too busy doing work in this case.

So we're in this position where they're giving us new documents for him, but actually pulling down available deposition opportunities. We have a request, and we can put it in a paper, that either we get a couple hours with him or -- on these new documents or he's not allowed to use them.

THE COURT: Well, when do you want to do that? I'm not sure I understand. You want a couple hours to --

MR. SCHMIDT: To depose him on these new documents, and we can do that any time.

THE COURT: Okay. Let me hear from the other side on this. Do you have any objection to that?

MR. FULLER: Yes, Your Honor, and I responded to them last night.

These are additional reliance documents, Judge. It does not change his opinion whatsoever. They've spent between this case and the other cases over 20 hours with Mr. Rafalski. There's no reason --

THE COURT: When did you produce these?

MR. FULLER: When did I indicate they were additional reliance documents?

THE COURT: Yes.

MR. FULLER: Yesterday, Judge, but they're documents they've had in their possession -- we've all had in our possession for an extended period of time.

THE COURT: But they were just identified to you; is that right?

MR. SCHMIDT: Yes.

THE COURT: A big stack of -- a flood of paper --

MR. SCHMIDT: Tens of millions of documents. It's new documents he's used that we've never had a chance to ask him about at a deposition which, of course, is why there is a disclosure requirement under Rule 26 that the witness identify documents they might use so you can depose them on those documents.

THE COURT: So the options would be to allow the deposition or not let him use the documents.

MR. SCHMIDT: Yes, that's our request. And we'll take either.

THE COURT: How about that?

MR. FULLER: Judge, I forego using the documents. Again, it's reliance documents. It doesn't change his opinion. It's just further support. And, again -- so the Court's clear, it's not somebody else's documents. It's their own documents.

MR. SCHMIDT: But we've had major issues with Mr.

Rafalski in terms of how much he's actually reviewed our documents, what he has to say about our documents, things like that. That's why we're asking for the deposition.

One of them is actually someone's lengthy deposition testimony. That is a proper subject of, of deposition discovery.

THE COURT: You can do this in two hours?

MR. SCHMIDT: Yep.

THE COURT: And you're representing in good faith to me you're genuinely surprised by this?

MR. SCHMIDT: Yes.

THE COURT: Okay. I'm going to allow it.

MR. FULLER: Judge, can I withdraw the documents then?

MR. SCHMIDT: We have no objection to that, Your Honor.

THE COURT: Yes, you may withdraw the documents.

MR. FULLER: Thank you, Judge.

THE COURT: This problem is hopefully solved.

MR. SCHMIDT: Yes, Your Honor.

MR. FULLER: Yes, Your Honor.

MR. SCHMIDT: No 25-page brief on that.

THE COURT: Well, my clerk will be glad to hear that.

(Laughter)

THE COURT: I just revealed that I haven't read every word that you've submitted.

(Laughter)

MR. SCHMIDT: No one understood it that way, Your Honor.

THE COURT: Okay. Call another witness.

MS. QUEZON: Yes, Your Honor. Good afternoon. Amy Quezon, Q-u-e-z-o-n, on behalf of the plaintiffs. And we call Connie Priddy to the stand.

THE CLERK: Would you please state your name.

THE WITNESS: Yes. Connie Priddy, P-r-i-d-d-y.

THE CLERK: Thank you. Please raise your right hand.

CONNIE PRIDDY, PLAINTIFFS' WITNESS, SWORN

THE CLERK: Thank you. Please take a seat.

THE WITNESS: Thank you.

MS. QUEZON: May it please the Court.

DIRECT EXAMINATION

BY MS. QUEZON:

Q. Good afternoon. Please introduce yourself to His Honor.

A. Good afternoon, Your Honor. My name is Connie Priddy.

Q. Okay. And, Ms. Priddy, can you please tell His Honor where you work?

A. I work for Cabell County EMS.

Q. And what is your title or role at Cabell County EMS?

A. My official title is Director of Quality Compliance.

Q. Do you have any other titles or roles with Cabell?

A. I actually do. I'm the Program Coordinator for the Huntington Quick Response Team.

Q. And we'll talk a little bit about your roles. Before we do, if we can give the Court a little bit about your background. Where did you -- where were you born and raised?

A. I was born and raised in Huntington, West Virginia. I've been there my entire life.

Q. Where did you go to college?

A. I went to Marshall University.

Q. And did you -- is that where you got your nursing degree?

A. Yes, ma'am. I graduated in 1981 from Marshall University School of Nursing. And also in 2000 I received my Master's Degree in sociology from Marshall University.

Q. And, Ms. Priddy, once you were licensed as a nurse, can you tell the Court where you went to work?

A. Yes. I originally went to work at Huntington Hospital. It was a very small hospital there in Huntington right out of nursing school. I worked there for about a year and a half. And then I went to Cabell-Huntington Hospital also in their emergency department.

Q. So you were an emergency room nurse at both hospitals?

A. Yes.

Q. Okay. And how long did you serve as an ER nurse at Cabell-Huntington?

A. At Cabell-Huntington I was -- it was about six and a half years.

Q. So are we up to, what, 1989-ish?

A. Yes. '88, early '89.

Q. And can you tell the Court where you went to work around 1989?

A. We actually ended up with a medical helicopter that flew out of Cabell-Huntington Hospital. And I applied and got the position with the medical helicopter. So I was a flight nurse after that period of time.

Q. Did you obtain any additional certifications or training in order to become a flight nurse?

A. Yes. You have to be registered with the West Virginia Office of EMS. So there was multiple certifications involved for that.

Q. And did you all only respond to trauma cases in West Virginia?

A. No, ma'am. We actually crossed state lines. We went into Ohio, West Virginia, and Kentucky just because Huntington is so close to the border there.

Q. And are you licensed in all those states as a nurse as

well?

A. Yes, uh-huh.

Q. And how long did you serve as a flight nurse, Ms. Priddy?

A. 25 years, a very, very long time.

Q. And can you tell the Court when you started at Cabell County EMS?

A. In 2011 they actually asked me if I would like to come and work for them part-time. I told them I wasn't ready to quit flying yet. So I did that for about a year part-time.

Q. And did you eventually take a full-time position at Cabell?

A. I did. In 2012 I went full-time there at Cabell County EMS.

Q. And what -- if you can remind the Court, what's your title there and what has it been since 2012?

A. So originally I went as Compliance Officer. That was actually just a continuous quality improvement person that -- my true goal was to improve the patient care of the field personnel. And then over the years, that title evolved to Director of Quality Compliance.

Q. And tell the Court, if you, if you will, how do you go about achieving that goal of making sure that the people of Cabell are receiving quality care from the, from the EMS paramedics and EMTs?

A. So various different ways, but a lot of the things that I did in the beginning were chart review, you know, look over a patient's care to make sure that they were following West Virginia protocols. We have a monthly meeting that we call a continuous quality improvement meeting. And, you know, I work directly with the field personnel on that.

Q. I want to talk to you a little bit about those charts if we can, Ms. Priddy, and eventually about EMS suspected overdose calls. But let's back up a little bit. What charting -- what type of charting do the paramedics and EMTs do out in the field?

A. So there's an electronic medical record that they have to fill out on every single patient contact they have. There is a certain demographic area, vital signs area, and also a narrative on that.

Q. And what are these referred to as in your industry?

A. Those are EMS run sheets. So -- and I had to do those for 25 years with helicopter too so --

Q. Now, are the EMTs and the paramedics the ones that are actually completing these, these run sheets?

A. Yes. The actual individual who goes on that particular run is the person that completes that chart.

Q. Do they have a computer in the ambulance?

A. What it is is the internet-based service where you can actually start it on like an iPad. They have what they call

tough-book computers. So they can go ahead and start that patient documentation when they first have patient contact. And then they can download it and finish it in the ambulance station afterwards.

Q. And, so, are the paramedics and EMTs, are they documenting at or near the time of whatever they're, the incident that they respond to?

A. Absolutely, yes.

Q. Okay. And can you tell the Court, what happens to these forms once the paramedics or the EMT has completed it?

A. So the form itself, you have to go through every process that it asks for. The chart is then locked. And then it is actually sent to the West Virginia Office of the EMS. And we require that they finish it before they go off shift.

Q. Okay. And can it be changed or altered in any way once it's been locked?

A. No, ma'am. There is an area where you can do an addendum to it, but that is time and date stamped. So if they make any additions to that, you know, it's documented there. So they cannot go back once it's locked and make changes.

Q. Now, Ms. Priddy, is the completion of these forms within the regular practice of the paramedics and EMTs?

A. Yes, that is part of their job description.

Q. And are these EMS run sheets that you've described for the Court, are they kept in the regular course of business by Cabell County EMS?

A. Yes, uh-huh.

Q. Now, you, you mentioned that when you first started working at Cabell County in 2011, was it the same type of electronic monitoring or electronic run sheets as are being used now?

A. No, ma'am. There was -- it was definitely electronic charting, but it was a different company at that point when I very first came.

Q. And did Cabell County EMS track overdose calls, suspected overdose calls in any way back in 2011 when you first started working there?

A. Yes, they did. Our Director of EMS actually had the people that work in billing to just sort of go through the charts as they were doing that billing, review them, and sort of very informally -- because that was the only way we had to track them at that point -- to do just rough guesstimates of how many overdose calls our reports were running at that point.

Q. And did the way Cabell EMS track suspected overdose calls change at some point?

A. Yes. So in 2014 we went to a different electronic medical record. And at that point, we were already aware

that we were seeing overdoses and we needed a more accurate objective way to track them.

So at that point, we were able to create a drop-down box. And one of the categories was suspected overdose. And that was something that the medical personnel on the scene would select.

Q. And when did this type of tracking, the more objective that you've described to the Court, when did Cabell County begin using that type of tracking for suspected overdose calls?

A. So we actually put the box in in October of 2014.

Q. And, Ms. Priddy, would showing the Judge an example of this new EMS run chart help explain the information that's included on that form?

A. Absolutely, yes.

MS. QUEZON: Your Honor, may I have permission to show you an example of the EMS form for demonstrative purposes only?

THE COURT: Yes.

BY MS. QUEZON:

Q. All right. So, Ms. Priddy, first of all, can you point out for the Court where that drop-down menu, the choice that the EMT or the paramedic has, where does that appear on the form we see on the screen?

A. So would you want me to touch the screen?

Q. If you, if you say where it is, I think someone will highlight it so everyone knows what you're talking about.

A. Okay, okay. In that Chief Complaint area, it says "Category," that is where that is captured.

Q. Now, you mentioned a drop-down menu. Can you tell the Judge how many choices do they have?

A. They have 45 choices.

Q. And what are some of the other choices, just a couple?

A. Abdominal pain, electrocution, cardiac arrest, a multitude of any type issue.

Q. Now, we've used the term "suspected overdose" and it's present here. It says "drug/alcohol overdose suspected." Can you tell the Court why the term "suspected" is used?

A. In my practice as a nurse, I was responsible for -- I didn't personally create the box because I'm not near that technical. But when I was having that box selected or developed, we were taught that you do not make a medical diagnosis in the field.

So it's suspected based on the fact that this is your best medical judgment, your expertise. In this particular field, this is what you are suspecting.

Q. Now, is there a way by looking at this form that, that you, Ms. Priddy, can, can look at the suspected overdose? Is there anywhere that you can look to see whether more likely than not this was an actual overdose?

A. So what I do is I actually -- there's a narrative. So you can see that in front of you. Would you want me to highlight some of the areas that I look at?

Q. Sure, yes, ma'am.

A. Okay. So, certainly, the first line that says "overdose on heroin," that would be an indicator. But what we are looking at more is the presentation of the patients themselves.

So we would look at things like -- the Sp02 is their oxygen level. A normal oxygen level is above 94 percent. So something that is not 60 percent means they're not oxygenating well.

I'm looking here to see -- the person also had a strong pulse. A lot of times people still have a pulse when they have an opioid overdose, but their respirations are affected, so their level of oxygen getting in and out is affected. But a lot of times they still have a strong pulse. So that would be something else that they would look at.

What we see is that they were breathing two times a minute, and they were actually assisted. Their respirations were assisted, which we call bag valve mask. It's what you see on TV where you squeeze the bag and you assist those ventilations.

So those are some of the indicators that we see that

lead you to believe that this is an overdose situation. The narrative is very clear on that.

Q. Now, on the narrative here it says two milligrams of Narcan was administered to patient nasally. Does that in any way -- is that in any way significant?

A. Yes. So we may have somebody that's unconscious and unresponsive. If we administer Narcan and the patient responds and becomes alert, then that is an indicator that it's an opioid overdose. It's not due to something else. It's an opioid overdose. If somebody is having a heart attack, they don't immediately respond from Narcan. So that's a really good indicator for us.

Q. Now, do you look at each one of these suspected overdose EMS run sheets personally?

A. Yes, ma'am. So what we do is through the Quick Response Team I actually review these every day. So I'm looking at them. I have eyes on them I guess is what you'd say.

Q. Now, let's go to just one more example for the Court. All right. Once again, if we -- up at the Chief Complaint, what's there?

A. Yes.

Q. All right. Anything in the narrative here that would lead you to the conclusion that not only is this a suspected overdose, but more likely than not it's an actual overdose

and more likely than not it's an opioid overdose?
A. Okay. Initially, I would list the patient as unresponsive, if they had pinpoint pupils. In any type of opioid overdose, the pupils are pinpoint. And that's another very good indicator that it is from an opioid. And, of course, again, you see that they were given two milligrams of Narcan and they responded to it.
Q. Now, you mentioned that pinpoint pupils is indicative of an opioid overdose. Have you -- in your career as a nurse and at Cabell EMS, have you responded to situations where the patient is -- has taken too much of a different type of substance like methamphetamine or cocaine?
A. Oh, yes, yes. And if, if they have what I call overdosed, they don't present without that -- with that depressed breathing. But if they've taken too much of a stimulant, then their pupils are dilated.

So it's a different presentation. They generally present in a very agitated state. We call it excited delirium. So they present in a whole different way than someone who has an opioid overdose.
Q. All right. Now, is there any way to determine what type of opioid caused the overdose just by looking observationally, meaning can you tell whether it was a prescription pill or heroin or fentanyl?
A. No, ma'am.

Q. And do -- does EMS commonly run a toxicology screen out on the field, out in the field?

A. No, that's not what we do at all. We're just in the, you know, that emergent situation of saving their life which is restoring their breathing generally.

Q. Now, you mentioned that you have since 2014, and 2014 with the new system, that you review these on a regular basis. Can you tell the Court how often you review the suspected overdose run sheets?

A. Yes. So I work Monday through Friday. My job is generally administrative. I review those every single day. I look at those and pull those after I come in in the morning.

Q. And have you, Ms. Priddy, calculated how many suspected overdoses occurred in Cabell County for 2015, 2016, 2017, and 2018?

A. Yes, ma'am. I -- that is one of the things that I have done is -- I'm the data keeper at Cabell County EMS as far as running that information.

MS. QUEZON: Your Honor, may I approach the witness?

THE COURT: Yes.

BY MS. QUEZON:

Q. Ms. Priddy, what are we looking at?

A. I am looking at a form that I had put together in just

a regular little Word file that states the overdose calls for Cabell County EMS.

Q. And are these numbers for overdose calls from 2015 to 2018 by quarter, did you yourself calculate these?

A. Yes, I did.

Q. And did you do this by calculating the -- just as we've gone through with the Court looking at suspected overdose calls and then verifying that it was more likely than not an actual overdose call?

A. Yes, uh-huh. And I, I do a search field with that drop-down box. And this is the numbers that objectively come out the other end. So --

MS. QUEZON: Your Honor, at this time we would move into evidence P-41060-0001.

THE COURT: Is there any objection?

MS. WU: No objection.

THE COURT: It's admitted.

BY MS. QUEZON:

Q. I'll do it better this time.

In addition to tracking the overdose -- suspected overdose calls that EMS did, did you also take it upon yourself to track the use of Narcan?

A. Yes, I did. I thought that would be valuable information to have to coincide with this information.

Q. And let me you ask, Ms. Priddy, are there times when a

patient receives more than one dose of Narcan?
A. Yes, uh-huh.
Q. And the tracking that you did, did you simply track when it was used or if they received multiple doses?
A. Just when it was used. So it was individual patient records, not how many was given to each patient.
Q. All right.

MS. QUEZON: Your Honor, may I approach the witness?

THE COURT: Yes.

BY MS. QUEZON:
Q. All right. Ms. Priddy, what are we looking at here?
A. So this is another document that I've created. It contains the same information, but I also included Narcan administration on this particular document.
Q. And would this be the drug overdose statistics from Cabell County Emergency Medical Service from 2015 patient transport -- is that really transport or what is -- is that something else?
A. So in the very beginning, I actually called them transports. And I realized that the more correct term is patient calls because not every single person is transported to the hospital, but they absolutely have to have a medical record.

So if I have patient contact, I have to make a medical record. I can't say because they didn't go to the hospital I don't have to make a chart because the boss would get mad. So they have to make a chart.

Q. And, so, is what we're looking at, 2015 and 2016, both Cabell County EMS overdose runs and Narcan administration?

A. Yes.

MS. QUEZON: Your Honor, at this time we would seek to move into evidence Plaintiffs' P-44281-0001.

THE COURT: Any objection?

MS. WU: No objection.

THE COURT: It's admitted.

MS. QUEZON: All right, last one, Your Honor. May I approach the witness?

THE COURT: Yes, you may.

BY MS. QUEZON:

Q. Now, Ms. Priddy, I realize this information is attached to an email and I'm more interested in the information itself. So if you can turn to Pages 2 and 3 of the document and tell us what we're looking at.

A. Okay. So these are -- in addition to the ones I have done -- and I continue to keep these each year. You can see the totals for the number of overdoses in 2017 was 1,831 for the year. And then in 2018 we actually have attached the numbers which are 1,089. So I've sort of documented at the

bottom the level of decrease in the overdoses between those two years.

MS. QUEZON: Your Honor, at this time the plaintiff would seek to move into evidence Exhibit P-41054-00001.

THE COURT: Any objection?

MS. WU: No objection.

THE COURT: It's admitted.

BY MS. QUEZON:

Q. Okay. Now, Ms. Priddy, as the Director of Quality Compliance, did you personally observe any effect on the Cabell County EMS first responders as a result of the increase in suspected overdoses?

A. So as the Director of Quality Compliance, I feel like my job is to improve patient care. So when I was having our field personnel come to me and say, "I feel angry and I don't know why --" we had one individual that was talking about suicidal thoughts.

We actually have an Employee Assistance Program in place that we can refer individuals to. We partner with one of the local hospitals.

COURT REPORTER: I'm sorry. Could you speak up, please?

THE WITNESS: I'm sorry.

So we, we have an Employee Assistance Program through

one of the local hospitals. There's a counselor that's associated with that. They will take referrals, immediate referrals if we see an individual that is struggling and we immediately refer them.

As we started to see increased incidences and -- can I -- so one of the incidences that really prompted this program that we ended up developing was there was a mother on the interstate that was opioid-impaired. She crashed her vehicle. Her children were killed.

We had police, fire, and ambulance on the scene. They were able to fly the young daughter out in critical condition. And the little girl that could still speak said, "Sissy, I don't know where Sissy is. I can't find Sissy."

And, so, the first responders found a really small shoe on the interstate and they knew that there was another child there. So they searched for an hour and a half for this child. They went over the embankment. They walked up and down the interstate. And they never found her.

And then someone looked down in the wreckage and they saw a little, teeny tuft of blond hair coming out of the wreckage. And they realized that little girl had been trapped all that time.

So at that point, the first responders on the scene broke down. We ended up having a debriefing, which happened very few and far between, but we ended up having a formal

debriefing. We had a group come in from another county.

Our EMS supervisor who had done his job for 25 years was in tears. One of the police officers that had been, you know, doing his job for 20 years, they were all in tears.

And suddenly we realized what we needed was something more than just this Employee Assistance Program where if somebody is in crisis, you refer them. We needed something to actually help the first responders prior to getting to that crisis situation in their life.

Q. I think there were two programs. What were the two programs if you can tell the Court?

A. Okay. So we had -- we developed a Critical Incident Stress Management Team, and that had all the first responders in Cabell County. So we had law enforcement. We had police, fire, and EMS in that. And we developed that. That is that debriefing team, and they're still in place now.

And we also developed what we call a Second Responders Program. We felt like this was a program to help the helpers.

Q. And, Ms. Priddy, did you create a poster to sort of let the, the first responders know that there was someone there that could help them?

A. Yes, absolutely. And it was developed with resource numbers on it. And we put it in each individual ambulance

station where the crews actually work out of.

MS. QUEZON: Your Honor, permission to publish it just for demonstrative purposes.

THE COURT: Yes.

BY MS. QUEZON:

Q. Is this the poster that you put together?

A. Yes, it is. So you can see we provided some basic information, things like EMS providers are 10 times more likely to commit suicide, some of the warning signs which people do not realize sometimes. You know, you go home and you feel angry with your family and you don't know why.

So we were trying to just let them see some of those and then give them resource numbers. So we gave them the Employee Assistance Program number. There's a crisis line with Prestera that is answered 24 hours a day. And also the National Suicide Hotline number is on there. So just trying to give them some resources because we knew they were hurting.

Q. Now, Ms. Priddy, as a result of the increase in overdoses that we've looked at with the Court, and some of the other issues that, that we've talked about that you saw going on in your community as a result of the increase in opioid overdoses, what, if anything, did you and some of the other community members do?

A. So we actually had an individual -- his name was Bob

Hanson. He was the Director of Addiction Sciences at Marshall Health. He's -- he was what I call -- he corralled the cats into the same room. We had police, fire, EMS. We had political leaders. We had Marshall University. We had both hospitals.

We very quickly realized when we got together that everyone saw the issues, but they saw it from their own perspective, you know. They saw how it was affecting their agency.

As we talked, we realized this is overwhelming our community. It's overwhelming our resources. We have got to look for answers. We've got to look for a way to address these issues.

And, so, I really feel so strongly about what our community did, that it came together and it said, "We are going to look for solutions." And I think that that's where we were at that point.

Q. And what did Mr. Hanson -- what was one of his suggestions?

A. So one of Mr. --

MS. WU: Objection, hearsay.

THE WITNESS: I'm sorry?

MS. WU: Objection, Your Honor, hearsay.

BY MS. QUEZON:

Q. What, if anything, did you do as a group?

THE COURT: I'm going to sustain the objection. Go ahead.

MS. QUEZON: Yes, sir. My apologies.

BY MS. QUEZON:

Q. What, if anything, did you decide to do as a group?

A. So as a group, we decided to look for ways to address this. And one of the things that we found was a Quick Response Team model in Colerain, Ohio. And they were able to come to Huntington and sort of just tell us basically what they were doing and how they were doing it and the level of success that they had with that.

Q. And after meeting with the group from Colerain regarding QRT, what, if anything, did you do?

A. We thought it was a wonderful idea. We said that this was utilizing first responders, which are the first point of contact in an overdose, and actually going to see people. We thought this was a great idea. We had no funding.

Q. So without money, what did you do then?

A. So without money, we applied for two federal grants. We applied for the first one hoping against hope we might get it. And then we found another grant opportunity that we thought we will apply, possibly we might get one or the other.

Q. And what happened?

A. We actually got approved for both.

Q. And how -- how long is the grant period, Ms. Priddy?

A. So we got approved in late September of 2017 for a three-year period.

Q. And how much was the grant from each of the two federal agencies?

A. Total close to 1.3 million, so roughly 400,000 a year.

Q. All right. Now, what does the Quick Response Team do?

A. So the Quick Response Team is what is called a First Responder Diversion Program. So that means first responders, EMS, law enforcement go out and actually visit an individual after they have overdosed.

Q. And how do you make that determination?

A. So we utilize the EMS data and, so, that way we know. We know who to go see. Very, very quickly we realized that we need to make sure -- because we had individuals say, "So you have to overdose to get help from the Quick Response Team?" And we're like, "Oh, absolutely not."

So we developed a referral number so you could call in and ask for help, so families could call in and ask for help, so individuals could call in and ask for help, so you did not have to have an overdose event.

Q. Who is on the team?

A. Okay. So on the team we have an EMS personnel, so we have a paramedic. We have a police officer. We have what I generally call a treatment provider, so somebody that's been

in behavioral health who has dealt with people with substance use disorder in the past. And also we have a faith leader. So we have many, many churches in our community that want us to do something and they wanted to be a part of, of the solution.

So I offered up. I said, "Well, you could offer your church as a safe haven. You could maybe provide food or clothing." And they said, "Absolutely not. We want to go out with the team and visit these individuals. We want to make that personal contact with them."

So we have four members of the team at any given day.

Q. And can you tell the Court when you -- when the first knock on the door happened?

A. So we found out that we had gotten grant approval October of 2017, and we knocked on the first door December 4th, 2017. We were ready. We were up and running. We had the resources. We had the community buying in. We were, we were so ready.

And what we said was if we wait until we solve all of these problems and all these questions, we'll still be talking about them a year from now. Let's just start going out and visiting these individuals.

Q. And, Ms. Priddy, how -- what was the reception -- well, first of all, let me ask you, in what time frame -- you say that often these are people that have overdosed. How

quickly does the Quick Response Team try to get to that person after they have had an overdose experience?

A. So that's a really good question. What we do generally is we say 24 to 72 hours. That's because the team only works Monday through Friday. We don't have enough funding to work weekends.

So really quickly. It is that rapid response within a 24-hour period during the week generally and maybe up to 72 hours. They still get the medical care they need. The ambulance still responds. They still get Narcan. You know, whatever they need, they still get, but they don't get that follow-up piece sometimes until 72 hours after.

Q. And do you call ahead or do you just show up at their house? How does what happen?

A. So we, we literally do what I call a cold call. We go and knock on their door. We don't call ahead. We don't make an appointment. We've got such buy-ins from our field personnel on occasion they'll say, "Somebody will come and talk to you tomorrow."

If you want help or you need in treatment or if you need anything, somebody's going to come. But generally we just show up and knock on the door.

Q. And what was the reception like initially from the people that you were trying to reach?

A. So sometimes at the scene of that overdose, it's a

little confrontational. Someone may have overdosed in public. They're embarrassed. They just want to get out of there. You know, our crews were very cynical at this point.

So we were a little bit leery that we may not be well received when we knock on somebody's door. And that first week we had the first two or three individuals and they looked at us and said, "So you're here to check on me? You cared enough to come to my house and check on me to see if I'm okay."

And we, we looked at each other and said, "We've got something here. This is going to work."

And I can't even tell you how grateful the families are. The families are just -- you know, they, they don't know where to turn. They don't know who to call. So if you knock on the door and you get a family member, they're thrilled.

Q. Does the team take anything with them on these QRT visits?

A. So we do provide Narcan, you know, because our, our first priority is to save somebody's life. That is our first priority.

Once the American Heart Association realized what we were doing they provided a little teeny -- it is truly a disposable CPR mannequin. It's in a little box about this big (indicating) and you blow it up. It's really tiny.

But to leave like a CPR mannequin -- which our paramedic makes sure to have the family understand that generally somebody's respirations are decreased. So you might be helping with their breathing. You may not be performing chest compressions. But give them that tool to explain that to them and then to provide that Narcan to them. They are so grateful.

We provide information on the Harm Reduction Program. So if they're not ready for treatment, they still have an option.

We, we also very -- within probably about a year, one of the things that we were doing was providing information in a little brown paper bag. And we had a research partner say, "A brown paper bag is a sandwich bag. That's a lunch bag."

So we started making peanut butter and jelly sandwiches for individuals. And I tell you what. They thought it was a steak dinner. They were just so excited.

And then once our churches realized that, they started donating peanut butter, donating bread, donating jelly, donating coats. And we even have one of our faith leaders like knit hats and scarves for individuals. I've got pictures of this massive amount of, you know, scarves that she was sitting and knitting.

So we really were going great guns. COVID sort of put

a nix on being able to distribute that.

Q. I was going to ask about that. So did you notice a change in tracking the overdose calls after QRT started their work?

A. So what happened initially is we started doing our visits in December of 2017. Within that first quarter, we started seeing some numbers trending downward.

By the second quarter after that, we saw them trending downward. But we were sort of afraid in the beginning to say these numbers are trending downward because we were afraid if we say that, it's going to jinx us.

So we waited really pretty much for two quarters before we reported out that downward trending of those numbers.

We, we actually had the Director of the Office of Drug Control Policy from the presidential office come and I did a presentation for him. He said, you know, "These numbers are going down. Why, why doesn't everybody know about this, you know, this model?" And --

Q. Ms. Priddy, would it help you to show just the, the tracking in a graph form?

A. Absolutely.

MS. QUEZON: Your Honor, may I show it for demonstrative purposes only?

THE COURT: Yes.

THE WITNESS: So you can see how the numbers were

trending up and up and up. And this is by month. Most people are very aware of the August of 2016 incident that we reported out about 28 overdoses in about a four-or-five-hour period. Something that became very obvious after that is no one was referred for treatment after that date.

And I continued to track those numbers. Every single month after 2016, that August of 2016, the numbers continued to trend upward until August of 2017. We had nearly 200 overdoses in one month which was averaging about six a day.

Q. And then this is the month in which -- December 17th is when you all started the QRT?

A. Yes, yes, ma'am.

Q. Now, you mentioned COVID. Can you tell the Judge what happened when QRT couldn't go out anymore?

A. So we went -- you know, I think it was probably about mid March in 2020 government services were shut down. We were working out of a government building. So the QRT shut down.

All those trending downward numbers tripled from April to May in 2020. So we realized really quickly how important that personal engagement component was to put your hand on somebody and tell them that we're here to help you, you know. This is a really, really difficult system to navigate. Healthcare in general is really hard to navigate.

Q. Well, Ms. Priddy, do people that QRT go to actually go

into treatment?

A. So of the individuals that we contact, we have contact with, about 30 percent of those individuals go into some type of formalized treatment.

Q. And even when they're willing, are there any other barriers? I think you mentioned the, the complicated healthcare system. Any other barriers to people getting treatment when they're willing to do so?

A. Cost. You know, they, they don't have the ability to pay. Sometimes -- our team has gotten really good that if they're eligible for some type of state funded, you know, insurance, they can link them with that.

But facilities a lot of times were asking for a huge amount of money up front and, you know, these individuals and their families couldn't afford that. So cost was probably number one on our list.

Transportation. You know, we make the assumption that somebody can get in their car and drive to treatment, especially if they're doing an out-patient treatment. But a lot of individuals can't go into a facility for like 30 days because they have a family. They have children at home. They have a job. They can't leave that.

So they're forced into like a -- not even forced. They elect into an out-patient setting. But they don't have the transportation to get there three times a week or, you know,

whatever is required of them.

Q. Now, Ms. Priddy, for purposes of the grant recording, have you personally looked at the EMS and QRT data to determine if there's a typical overdose patient?

A. So demographic wise we certainly -- you know, I learned a lot. The average age of someone who overdoses is 37 years old.

As far as male versus female, probably about 60 percent male, 40 percent female.

After that, there is no typical overdose person. There really -- it cuts across every socioeconomic line. Our team will tell you that they have sat in an apartment with a dirt floor and a mattress and they sit in million-dollar homes. And it cuts across gender. It cuts across race. It cuts across every socioeconomic line.

So there is no typical person that overdoses. I say this, and I believe this with all my heart. When you see an individual now who may be gaunt with a hoodie on, it's not where they started. They started as somebody's son or somebody's daughter playing in the backyard, playing T-ball. I mean, you know, there isn't a typical. I know too many people.

Q. Ms. Priddy, you mentioned that you received that grant. Were you able to renew the grant?

A. So the grant was actually set to expire last year in

2020. That was the three-year period. We were able to, because we actually managed the funds really, really well, to ask for a no-cost extension. So they didn't provide us any more money. They just provided us some more time. So that is set to expire in just a few weeks.

Q. When does it expire?

A. July 1st. Well, actually June 30th.

Q. Can you tell the Court what does, what does the -- what does QRT need to continue its work?

A. So we need reliable, sustainable funding. This will go on long after I'm retired because I'm old. This will be generational. This will continue to go.

This model works. This model needs sustainable funding. And it has been picked up all across the country. And what makes this model work is that people out there touching individuals where they are, not waiting for them to come to them sitting behind a desk. They are going to those individuals and offering help, and help to families.

MS. QUEZON: Your Honor, may I have a moment to confer?

THE COURT: Yes.

(Pause)

BY MS. QUEZON:

Q. Ms. Priddy, in addition to the, to what the QRT team does now, are there ways that you would like to

improve it?

A. Absolutely. What I would love to have is a follow-up team so if an individual maybe goes into treatment that we could follow up with that individual because right now we're sort of relying on the facility that we've referred them to to do that follow-up piece. That would be so nice to have our team be able to follow up, see if they need anything. "Are you still doing good?" You know, because we've seen so many people get well. We want to make sure that they continue on that path.

We would love to focus more on that healthcare aspect. We were able during COVID, because we were having a hard time reaching everyone, is that we actually set up a tent and backed an ambulance in and opened the doors. We gave flu shots. We did Narcan training. We did HIV testing. And even the last event we did, we did COVID testing.

Q. And is this partnering with other agencies and other hospitals?

A. Absolutely, our Health Department, our local health.

MS. QUEZON: Thank you, Your Honor. Nothing further. We pass the witness.

THE COURT: You may cross-examine.

CROSS EXAMINATION

BY MS. WU:

Q. Good afternoon, Ms. Priddy. I'm Laura Wu and I

represent McKesson.

You spoke earlier this afternoon about some of your nursing career and I'd like to circle back to start there.

You spent nearly a decade as an ER nurse both at Huntington Hospital and Huntington/Cabell Hospital; correct?

A. Yes, uh-huh.

Q. You're still licensed as a nurse today?

A. Yes.

Q. When you were working as a nurse, you administered opioids to patients; correct?

A. Yes.

Q. Opioids have medically appropriate purposes; correct?

A. Yes.

Q. Physicians can legitimately prescribe opioids?

A. Yes.

Q. Nurses such as yourself can administer them?

A. Yes.

Q. Pharmacies can legitimately dispense prescription opioids; correct?

A. Yes.

Q. In fact, opioids are indicated for use in many emergency situations; correct?

A. Yes.

Q. For example, you use opioids, prescription opioids for a burn patient; correct?

A. Absolutely, yes.

Q. Or a patient with a broken bone?

A. Yes.

Q. As part of your job as a flight nurse, you collected information from patients on the medications that they were taking; correct?

A. Yes.

Q. That was part of your intake process?

A. Yes, it was.

Q. At some point in the early 2000s you started to see more patients who had been prescribed opioids by their physicians; correct?

A. Yes, uh-huh.

Q. During the course of your nursing career, you learned that team management became a higher priority in the medical profession; correct?

A. So on the helicopter we always addressed pain management. So I can't speak to really what they were doing in the hospital. I just know what we were doing in the field.

Q. Ms. Priddy, you're familiar with an organization called the Joint Commission on Accreditation of Healthcare Organizations; correct?

A. Yes, uh-huh.

Q. That's an organization that accredits hospitals around

the country like the hospitals in Cabell County where you work; correct?

A. Yes, uh-huh.

Q. You understand that pain management became one of the criteria that the Joint Commission evaluated in deciding whether or not to accredit a hospital; correct?

A. I, I did not work -- I worked for Cabell-Huntington Hospital, but I was not part of the JCAH interview process. So I honestly don't know.

Q. You didn't learn that in the course of your nursing career?

A. That JCAH made that a criteria for them? No.

Q. Okay. Ms. Priddy, you obtained your nursing degree in 1981 I believe you said?

A. Yes, uh-huh.

Q. And at that time, nurses were not taught to treat pain as the fifth vital sign; correct?

A. Correct.

Q. At some point thereafter, the concept of pain as a fifth vital sign was introduced; correct?

A. Yes. I had heard that term absolutely.

Q. That put pain on the same level of importance as a patient's temperature or respiration; correct?

A. Yes.

Q. And nurses then had to ask the patients to rate their

scale on a -- rate their pain on a scale of 1 to 10?

A. Yes.

Q. And if a patient indicated pain, the medical professional needed to address it; correct?

A. Yes, even though that was not our criteria we used on the helicopter, but, yes.

Q. Now I'd like to talk about the time you spent at EMS in Cabell County.

You understand that in recent years doctors have been encouraged to prescribe fewer opioids; correct?

A. Yes, ma'am.

Q. But even today, opioids have a legitimate role in medical care; correct?

A. Correct.

Q. West Virginia requires all EMS ambulances in the state to carry certain medications in order to obtain certification; correct?

A. Correct.

Q. West Virginia requires all ambulances to stock opioid medications; correct?

A. Correct.

Q. West Virginia also puts out protocols that every EMS must follow; correct?

A. Correct.

Q. Now, I'd like to show you some of those and I'd like to

mark Defendants' West Virginia Exhibit 263. Sorry. This is a big one.

Ms. Priddy, you have in front of you a copy of the 2019 edition of the Paramedic Treatment Protocols. Do you see that?

A. Yes, uh-huh.

Q. Ms. Priddy, you're familiar with this document from your work with Cabell County EMS; correct?

A. Yes.

MS. WU: Your Honor, I move the document into evidence.

THE COURT: Is there any objection?

MS. QUEZON: No objection, Your Honor.

BY MS. WU:

Q. Ms. Priddy, I'd like to ask you to turn to Page 47 of the document. This is the protocol for chest pain discomfort/acute coronary syndrome. Do you see that?

A. No, I don't. Wait.

Q. I'm sorry. I jumped ahead.

A. I'm looking for the actual page number. Oh, I see it. Okay. I see it.

Q. I'll repeat my question, Ms. Priddy. So Page 47 of the document is the protocol for chest pain discomfort/acute coronary syndrome. Do you see that?

A. Yes, I do.

Q. And it instructs if chest pain persists, EMS agencies throughout the state are directed to either administer morphine sulfate or administer fentanyl. Do you see that?

A. Uh-huh.

Q. Both morphine sulfate and fentanyl are prescription opioids products; correct?

A. Correct.

Q. Ms. Priddy, I'd like you to turn to Page 157 of the document. Page 157 is a protocol for patient comfort or pain management. Do you see that, Ms. Priddy?

A. Yes, I do.

Q. It states if a patient is in severe pain, EMS agencies throughout the state are directed to either administer fentanyl or administer morphine sulfate.

Do you see that, Ms. Priddy?

A. Yes, uh-huh.

Q. And, again, fentanyl and morphine sulfate are prescription opioids?

A. Yes.

Q. I'd like to ask you to turn to Page 159 of the document.

Ms. Priddy, Page 159 is the protocol for rapid sequence intubation. Do you see that?

A. Yes, I do.

Q. This refers to the -- this provides instructions for

when a patient needs rapid airway; correct?

A. Yes, uh-huh.

Q. Now, if we turn to the next page, Page 160, step two of the RSI procedure is to administer fentanyl. Do you see that?

A. Yes, I do.

Q. And on the next page, Page 161, it says once intubation is confirmed, if patient requires continued sedation or analgesics, EMS agencies are to provide and repeat as necessary fentanyl or morphine for sedation. Do you see that?

A. I do.

Q. And, again, fentanyl and morphine are both opioid medications?

A. Yes.

Q. Ms. Priddy, administration of opioids is part of the accepted treatment for EMS; correct?

A. Correct.

Q. And pursuant to these protocols that we've reviewed, Cabell County EMS carries opioids in all of its ambulances; correct?

A. Yes, uh-huh.

Q. And Cabell County EMS used opioids in emergency response situations?

A. Yes.

Q. And that's consistent with the statewide protocols that you've just reviewed?

A. Yes.

Q. In fact, Cabell County administered fentanyl just -- I'm sorry. Cabell County -- Ms. Priddy, in fact, Cabell County administers fentanyl when required to patients in its care; correct?

A. Yes.

Q. In the first nine months of 2017 alone, Cabell County EMS administered fentanyl at least 137 times; that right?

A. I'm assuming. I don't see a document, so I don't know. I don't have those statistics in front of me.

Q. Sure. Let me show you a document just to help you there.

A. Thank you.

Q. Ms. Priddy, I'm showing you a document which is Defendants' West Virginia 260 for identification. And this is a spreadsheet logging Cabell County EMS administrations of fentanyl and morphine. Do you see this, Ms. Priddy?

A. Yes, I do, uh-huh.

Q. Are you familiar with this document, Ms. Priddy?

A. Not particularly. I did not create this document. But --

Q. Are you aware that Cabell County EMS tracks administration of fentanyl and morphine?

A. Absolutely, yes.

Q. And are you familiar with this document as the form in which Cabell County EMS tracks those administrations?

A. I'm not -- not this particular form. I know that it is tracked. I don't know if it's always put into this type of form but, yes.

Q. Thank you, Ms. Priddy. If you look at Pages 2 and 3, it reflects that Cabell County EMS administered fentanyl 137 times. Do you see that tally?

A. Was that this page?

Q. If you look at the bottom of -- I'm sorry, page --

A. I see it. Okay. Nevermind. I'm sorry.

Q. We get the tally of 137 administrations. Do you see that?

A. Yes, I do see that.

Q. Thank you. Ms. Priddy, I'd like to return to a topic you testified about earlier which is the EMS overdose data.

A. Yes, ma'am.

Q. You discussed Cabell County's experience responding to opioid overdoses. And you described the records that EMS now keeps. Correct?

A. Yes.

Q. Among other things, for each run EMS records the type of call. That's using the drop-down box that you referenced earlier. Correct?

A. Yes, Uh-huh.

Q. One type of call which you described is the suspected overdose call; correct?

A. Yes.

Q. All suspected overdoses are categorized the same no matter what substance is involved; correct?

A. Yes.

Q. Cabell County EMS does not make any determination in the field about the type of substance involved; correct?

A. Correct.

Q. Even when a toxicology report is prepared, that report is not sent back to Cabell County EMS; correct?

A. Correct.

Q. So Cabell County EMS does not record how many suspected overdose runs were due to opioids versus any other substance; correct?

A. No. Cabell County EMS does not, no. Is that what you're asking?

Q. That's correct. So Cabell County does not have a -- I'm sorry. Let me try that again. So Cabell County does not have a record of suspected overdose runs specific to opioid events; correct?

A. Other than the fact that they are categorized as such and then I physically review them. And within my experience level, probably about 95 percent of our calls are opioid

related.

Q. The overdose run data that you maintain does not specify a type of drug involved in the overdose run data; correct?

A. No, it does not.

Q. Cabell County EMS does not attempt to identify the source of the drug involved in the overdose event; correct?

A. Correct.

Q. Ms. Priddy, you cannot say, for example, whether the vast majority of opioid overdoses include heroin and fentanyl or a prescription opioid medication; correct?

A. Correct.

Q. Nonetheless, you do know that heroin is a problem in Cabell County; correct?

A. Correct.

Q. And you also know that fentanyl is a problem in Cabell County; correct?

A. Correct.

Q. Drug cartels lace fentanyl into heroin; correct?

A. I'm assuming, yes.

Q. And drug cartels also lace fentanyl into cocaine and other non-opioid class drugs; correct?

A. Correct.

Q. They also lace fentanyl into meth which is on the rise in Cabell County; correct?

A. I'm assuming, yes. I don't know that specifically.

Q. You also know that carfentanil is a problem in Cabell County; correct?

A. I do not have personal knowledge of that, but --

Q. Ms. Priddy, are you aware that in August of 2016, 26 people overdosed in a single day when a drug dealer from Akron, Ohio, was giving away free samples that were laced with carfentanil?

A. Yes.

Q. And that's the overdose event that you described in your testimony earlier today?

A. It is.

Q. Carfentanil is an illicit drug; correct?

A. Correct.

Q. Ms. Priddy, to the extent an individual overdoses on a prescription opioid, Cabell County EMS does not make any attempt to determine whether the individual who overdosed had a valid prescription for that medication; correct?

A. No. We are just treating the patient's condition.

Q. And you would not have any way to investigate that as EMS; correct?

A. No.

Q. In fact, you're not aware of anyone who has tried to determine the percent of opioids in Cabell County that were taken for something other than a legitimate medical purpose;

correct?

A. I do not know, no.

Q. Ms. Priddy, to the extent that an individual overdoses on a prescription, prescription opioid, EMS does not make any attempt to determine the pharmacy that dispensed that medication; correct?

A. Correct.

Q. Or the distributor who supplied that pharmacy; correct?

A. Correct.

Q. To the extent that an individual overdoses on an illegal opioid like heroin or fentanyl, EMS does not make any attempt to determine whether the individual ever had a valid prescription for an opioid medication; correct?

A. Correct.

Q. And you're not aware of any data on the percentage of people using illegal drugs in Cabell County who started with a legal prescription medication for an opioid; correct?

A. Am I aware of any data that is out there?

Q. That's correct, in Cabell County.

A. Yes.

Q. Ms. Priddy, you are, you are aware of data specific to Cabell County which identifies the prescription drug history for individuals currently using illicit heroin and fentanyl?

A. Yes.

Q. What's the source of that information?

A. The Cabell-Huntington Health Department. They actually interview the individuals that come into their Harm Reduction Program.

Q. And that's not an EMS data set?

A. No, it is not.

Q. And you don't know how that information is compiled; correct?

A. No, through an interview process.

Q. Earlier today, Ms. Priddy, you described that the average overdose victim that EMS encounters is a 37-year-old individual; correct?

A. Yes.

Q. Through your medical career, have you come to know that the average recipient of a prescription opioid medication through a doctor's prescription is 55 to 65 years old?

A. No, I do not.

Q. You don't know that?

A. No.

Q. Now, a short while ago you described a turn-around in Cabell County; correct?

A. Yes, ma'am.

Q. Suspected overdose runs have declined in recent years; correct?

A. Correct.

Q. You looked at some data, but I've got a little bit

more.

MS. WU: Could I get McKesson West Virginia 2098, 2099, 2100, 2101, please.

BY MS. WU:

Q. Ms. Priddy, the document which I've identified for you includes overdose statistics maintained by Cabell County EMS; correct?

A. Correct.

Q. You looked at a similar set of data with counsel just a short while ago; correct?

A. Uh-huh.

Q. Now, the documents that we've put in front of you show every month from October, 2014, through March, 2021. Do you see that?

A. I do.

Q. And this is all overdose runs recorded by Cabell County EMS regardless of what type of substance was involved in the overdose event; correct?

A. Yes. This is from the medical category drop-down box.

Q. And it's not limited to opioids generally or prescription opioids specifically. It's all drugs?

A. Yes, anything that would be classified suspected overdose, yes.

Q. Okay. Thank you, Ms. Priddy.

Now, I'm going to show you our version of a chart.

MS. WU: So, Mr. Reynolds, could I ask you to pull up the demonstrative which accompanies this data.

BY MS. WU:

Q. Ms. Priddy, this is a chart that we've made which tracks this longer period of data which is reflected in the four exhibits that you have in front of you. We've plotted that data just so we could speak about it here.

As you mentioned in your testimony earlier today, suspected overdoses peaked in 2017; correct?

A. Yes, uh-huh.

Q. Between 2017 and 2018, the number of suspected overdose runs declined by 40 percent; correct?

A. Correct.

Q. That amounts to a decline of nearly 750 overdose runs by Cabell County EMS; correct?

A. Yes.

Q. The number of suspected overdose runs declined by another 200 runs in 2019; correct?

A. Correct.

Q. In fact, from 2017 to 2019 the suspected overdose runs declined by more than half; correct?

A. Yes, uh-huh.

Q. That decline corresponds to a decline in overdoses overall in Huntington/Cabell County; correct?

A. Correct.

Q. Between 2017 and 2018 fatal overdoses declined by 24 percent; correct?

A. Correct.

Q. In fact, Cabell County's decline in fatal overdoses outpaced West Virginia's decline as a whole; correct?

A. Correct.

Q. Ms. Priddy, in your experience, the decrease in overdoses is due to the collaboration in the community which you described a short while ago; correct?

A. Correct.

Q. For instance, the community has opened several treatment facilities; correct?

A. Correct.

Q. The Quick Response Team is now able to find a treatment bed for every person in need; correct?

A. Most generally, more so than in '17.

MS. WU: Mr. Reynolds, could I ask you to pull up Ms. Priddy's deposition, Page 275, Line 19.

MS. QUEZON: Objection, improper impeachment if that's what's being attempted.

THE COURT: Well, overruled. I don't know where you're going with this.

BY MS. WU:

Q. Ms. Priddy, you were deposed in this case last summer; correct?

A. Correct.

Q. And you testified under oath at your deposition?

A. Yes.

MS. WU: And, Chris, could you go to Page 257, please.

BY MS. WU:

Q. And if we go to Line 19, it reads, "Is there some issue with the capacity for treatment recovery referral in your area?"

You answered, "You mean the ability to accept patients once they would want treatment?"

MS. QUEZON: Where are you reading? It's not on the screen. I apologize.

MS. WU: Oh, I'm sorry. Deposition Page 275, Line 19. I'm sorry.

MS. QUEZON: No worries.

MS. WU: Thank you, counsel.

BY MS. WU:

Q. And then your answer: "In the beginning, certainly there was, but there's a lot more resources now. So I do not hear the team saying we could not find a bed, we could not find a program. You know there's a lot more resources now than there were three years ago."

Do you see that, Ms. Priddy?

A. I see the big screen. I don't --

Q. I apologize for the technical difficulties.

A. That's okay. I'm not very technical.

Q. Do you see that, Ms. Priddy?

A. Yes, I see it, uh-huh.

Q. And that was your testimony under oath; correct?

A. Yes, uh-huh.

Q. Ms. Priddy, in fact, you've been -- you've stated that you have enough resources in the community now in that in your opinion it can only get better; correct?

A. We have much more resources than we had in '17, yes, absolutely.

Q. And in your opinion, it can only get better; correct?

A. I think if we continue to address the issue, it can only get better, yes.

Q. Your experience has shown a big part of the improvement is due to the work of the QRT team; correct?

A. Correct.

Q. And the QRT team, as you mentioned a short while ago, has become a model for other cities throughout the country?

A. Correct.

Q. The QRT has had a significant impact on the number of overdoses in Cabell County; correct?

A. I would like to believe that, yes.

Q. And that's been borne out by the COVID-19 pandemic; correct?

A. Correct.

MS. WU: Now, Mr. Reynolds, could we put the demonstrative of overdose runs back up.

BY MS. WU:

Q. Earlier you described the impact that COVID had on overdoses in Cabell County. In the first three months of 2020, which we see at the end of this graph, the number of suspected overdose runs was about equal to what it was in 2019. Do you see that, Ms. Priddy?

A. I do.

Q. But when COVID hit, the QRT team was not able to make face-to-face visits as you've just testified; correct?

A. Correct.

Q. People were isolated; correct?

A. Correct.

Q. They didn't have personal connections; correct?

A. Correct.

Q. They couldn't have face-to-face interactions with the QRT team; correct?

A. Correct.

Q. And that inhibited access to treatment; correct?

A. Yes. They did not have that information on hand being given by an individual.

Q. As a result, when QRT stopped operating in person, the number of suspected overdose runs started to increase in

April of 2020; correct?

A. Correct.

Q. After overdoses --

A. No, not until May. I'm sorry. In April they were --

Q. And -- I'm sorry. Did you say they spiked in May?

A. Yes.

Q. I'm sorry.

A. I'm sorry. Yes.

Q. So after the overdoses spiked at the beginning of the pandemic, they came back from their peak; correct?

A. We battled it all through the summer, yes, once we were out there making personal visits again.

Q. And the overdose run rate went down once the QRT program was up and running in person again; correct?

A. Yes.

Q. Now, as you described a short while ago, funding for the QRT team has come from grants up to this point; correct?

A. Correct.

Q. Huntington and Cabell received $1.35 million in federal grant money for the QRT team; correct?

A. Correct.

Q. And those grants have covered all of the QRT team's costs up to this point; correct?

A. Correct. Well, not, not all of them. We've been provided in kind -- Cabell County EMS has provided a

vehicle, maintenance, fuel, medical, I'm sorry, insurance. We have also been provided an office. So it has paid the salaries of the individuals on the scene, but not a lot of the other expenses.

Q. The grants cover the personnel costs for QRT; correct?

A. Yes.

Q. In addition, the QRT receives naloxone at no cost; correct?

A. Not directly, no. There was grants that provided naloxone to the QRT team in the very beginning. So, yes, through that grant program. That was not a state-funded program.

Q. So the QRT has not had to pay for naloxone; correct?

A. Correct.

Q. It's received naloxone through grant funding; correct?

A. Correct.

Q. In fact, the QRT team actually saves Cabell County money by reducing the number of overdoses in the area; correct?

A. The way we view it is we are not getting reimbursed for those costs. And, yes, that would be a money-saving to the agency itself.

Q. Now, Ms. Priddy, I'd like to switch topics and talk a little bit about the resiliency plan.

Ms. Priddy, the resiliency plan purports to have set

out a plan to respond to the opioid crisis in Cabell County.

THE COURT: Ms. Wu, it's obvious to me we're going to have to bring Ms. Priddy back tomorrow. This might be a good place to stop.

MS. WU: I'm happy to, Judge.

THE COURT: Okay. I assume we're not going to be able to finish her in 10 or 15 minutes, are we?

Ms. Priddy, the bad news is you're going to have to come back tomorrow.

THE WITNESS: Okay. I will do whatever is needed, sir.

THE COURT: All right. We'll be in recess until 9:00 in the morning. And we'll just go half a day tomorrow.

(Trial recessed at 4:59 p.m.)

CERTIFICATION:

I, Ayme A. Cochran, Official Court Reporter, and I, Lisa A. Cook, Official Court Reporter, certify that the foregoing is a correct transcript from the record of proceedings in the matter of The City of Huntington, et al., Plaintiffs vs. AmerisourceBergen Drug Corporation, et al., Defendants, Civil Action No. 3:17-cv-01362 and Civil Action No. 3:17-cv-01665, as reported on May 6, 2021.

S\Ayme A. Cochran
Reporter

s\Lisa A. Cook
Reporter

May 6, 2021
Date

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